CCME

2016 External Quality Review

ABSOLUTE TOTAL CARE

Submitted: February 23, 2017

Prepared on behalf of the
South Carolina Department
of Health and Human Service

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies that contract with Managed Care Organizations (MCOs) to evaluate their compliance with the state and federal regulations in accordance with 42 Code of Federal Regulations (CFR) 438.358. The purpose of this review was to determine the level of performance demonstrated by Absolute Total Care (ATC) since the 2015 annual review. This report contains a description of the process and the results of the *2016 External Quality Review (EQR)* conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the South Carolina Department of Health and Human Services (SCDHHS).

Goals of the review were to:

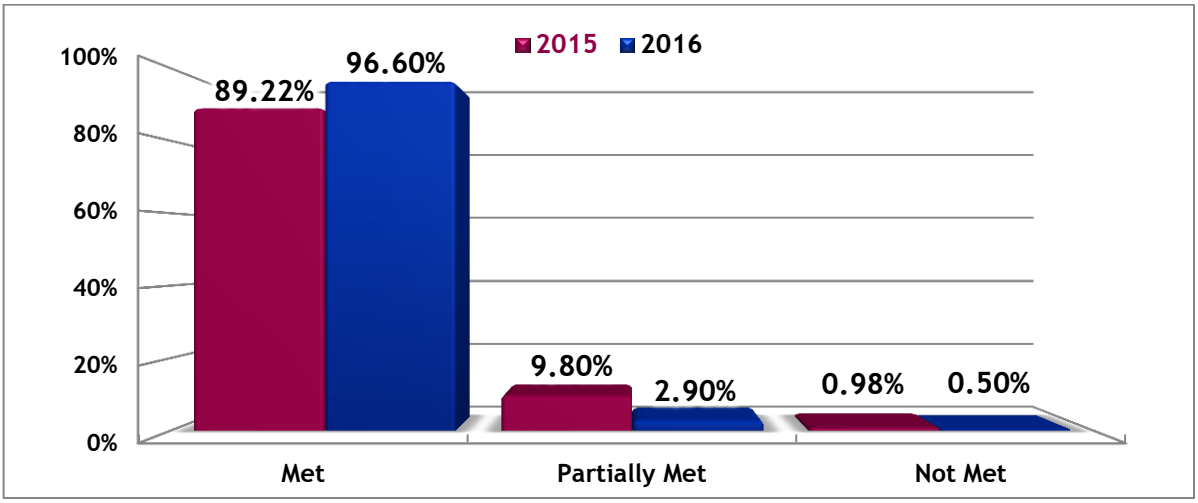
- Determine if ATC was in compliance with service delivery as mandated in the MCO contract with SCDHHS
- Evaluate the status of deficiencies identified during the 2015 Annual Review and any ongoing quality improvements taken to remedy those deficiencies
- Provide feedback for potential areas of further improvement; and
- Assure that contracted health care services are actually being delivered and are of good quality

CCME's EQR process is based on the Centers for Medicare & Medicaid Services (CMS) protocols developed for external quality review of Medicaid MCOs. The process includes a desk review of documents, a two-day onsite visit, a telephone access study, a compliance review, validation of performance improvement projects (PIPs), and validation of performance improvement measures.

Overall Findings

The 2016 annual EQR review shows that ATC has achieved a "Met" score in 96.60% of the standards reviewed. *Figure 1, Annual EQR Comparative Result*s, indicates 2.9% of the standards were scored as "Partially Met," and 0.50% of the standards scored as "Not Met." *Figure 1* also provides a comparison of ATC's current review results to the 2015 review results.

Figure 1: Annual EQR Comparative Results



An overview of the findings for each section follows. Details of the review as well as specific strengths, weaknesses, applicable quality improvement items, and recommendations can be found further in the report narrative.

Administration:

ATC has an experienced leadership team and adequate staffing in place to meet their members' physical and behavioral healthcare needs. The Compliance and Ethics Program and Fraud, Waste, and Abuse Plan combine to document their commitment to meeting all federal and state requirements for program integrity. Claims processing is efficient and a Disaster Recovery Plan is in place that was last tested in May 2016.

Provider Services:

ATC's credentialing program is comprehensive and policies address specific state requirements. For the credentialing file review, three organizational files did not contain proof of query for the *SC Excluded Providers List*, but overall the files were in good order. A few standards received "Partially Met" scores because updates to applicable policies were absent. Results of the CCME-conducted Telephonic Provider Access Study did not show improvement from the previous year's review. The successful answer rate was 43% for the current year and 52% for the previous year.

Member Services:

A review of Member Services revealed consistent information is provided in the *Member Handbook*. While ATC conducts regular outreach to their members and the community about preventive health screenings and immunizations, CCME recommends that ATC implement strategies to improve member survey response rates. The process for handling

grievances is consistent; however, the documentation of all the steps taken to resolve grievance was not found in several grievance files reviewed. This was especially true when the grievance was sent to another department for resolution. Policies did not include how ATC handles requests to change primary care providers due to dissatisfaction or who makes the decision on grievances related to the denial of an expedited appeal.

Quality Improvement:

ATC provided the 2016 *Quality Assessment and Performance Improvement Program Description* for review. This program description described the program the health plan has in place to monitor, analyze, evaluate, and improve member health care. All of the standards in the quality improvement section received a "Met" score. The performance measures and performance improvement projects met the CMS validation protocol.

Utilization Management:

Utilization Management (UM) functions and processes are generally well-documented in UM policies, the *Utilization Management Program Description*, *Member Handbook*, and *Provider Manual*. However, the policy addressing member appeals does not adequately define which staff members issue determinations that appeals requested as expedited do not involve an imminent and/or serious threat to a member's health. Review of UM approval and denial files, case management (CM) files, and member appeal files confirm staff follows established processes and contractual requirements. ATC has established a Preferred Provider Program and currently has one provider with a Preferred Status. They continue to add providers to the program.

Delegation:

ATC delegates various functions such as behavioral health, pharmacy benefit management, vision, nurse hotline, disease management, radiology, and credentialing/recredentialing. Appropriate processes are in place for delegation initiation and oversight.

State Mandated Services:

ATC provides members with all core benefits required by the *SCDHHS Contract*. ATC uses claims, encounter, and pharmacy data to identify members eligible for wellness activities; and uses a variety of methods, including the *Member Handbook*, educational mailings, phone calls, and the member portal to encourage members to participate in those activities and services. Provider compliance with provision of required Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, including immunizations, is routinely monitored via medical record audits. All deficiencies from the previous EQR were addressed.

Table 1, Scoring Overview, provides an overview of the findings of the current Annual Review as compared to the findings of the 2015 review.

Table 1: Scoring Overview

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards
Administration						
2015	33	0	0	0	0	33
2016	33	0	0	0	0	33
Provider Services						
2015	67	6	2	0	0	75
2016	71	3	1	0	0	75
Member Services						
2015	33	4	0	0	0	37
2016	35	2	0	0	0	37
Quality Improvement						
2015	15	0	0	0	0	15
2016	15	0	0	0	0	15
Utilization						
2015	29	9	0	0	0	38
2016	37	1	0	0	0	38
Delegation						
2015	1	1	0	0	0	2
2016	2	0	0	0	0	2
State Mandated Services						
2015	4	0	0	0	0	4
2016	4	0	0	0	0	4

METHODOLOGY

CCME's EQR process and activities follow CMS-developed EQR protocols for Medicaid MCO/Prepaid Inpatient Health Plan (PIHP), and focuses on the following three federally mandated EQR activities:

- Compliance determination
- Validation of performance measures, and
- Validation of PIPs

On December 5, 2016, CCME sent notification to ATC announcing the Annual EQR's initiation (see Attachment 1). This notification included a list of materials required for a desk review and an invitation for a teleconference to allow ATC to ask questions regarding the EQR process and the requested desk materials.

The review consisted of two segments. The first was a desk review of materials and documents received from ATC on December 19, 2016. CCME performed this review in our office (see Attachment 1). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the Quality Improvement and Medical Management programs. Also included in the desk review was a review of credentialing, grievance, utilization, case management, and appeal files.

The second segment was an onsite review conducted on January 26th and 27th at ATC's office located in Columbia. The onsite visit focused on areas not covered in the desk review or needing clarification. See Attachment 2 for a list of items requested for the onsite visit. Onsite activities included an entrance conference; interviews with administration and staff; and an exit conference. All interested parties were invited to the entrance and exit conferences.

FINDINGS

We summarize EQR findings in the sections that follow. CCME's findings are based on the regulations set forth in title 42 CFR § 438, and the contract requirements between ATC and SCDHHS. We identify strengths, weaknesses, and recommendations where applicable. Areas of review are identified as meeting a standard "Met," acceptable but needing improvement "Partially Met," failing a standard "Not Met," "Not Applicable," or "Not Evaluated," and are recorded on the tabular spreadsheet (Attachment 4).

A. Administration

The Administration review focused on the health plan's policies, procedures, staffing, information system, compliance, and confidentiality. Absolute Total Care's (ATC) policies and procedures are organized in a consistent manner, reviewed annually, and updated as needed.

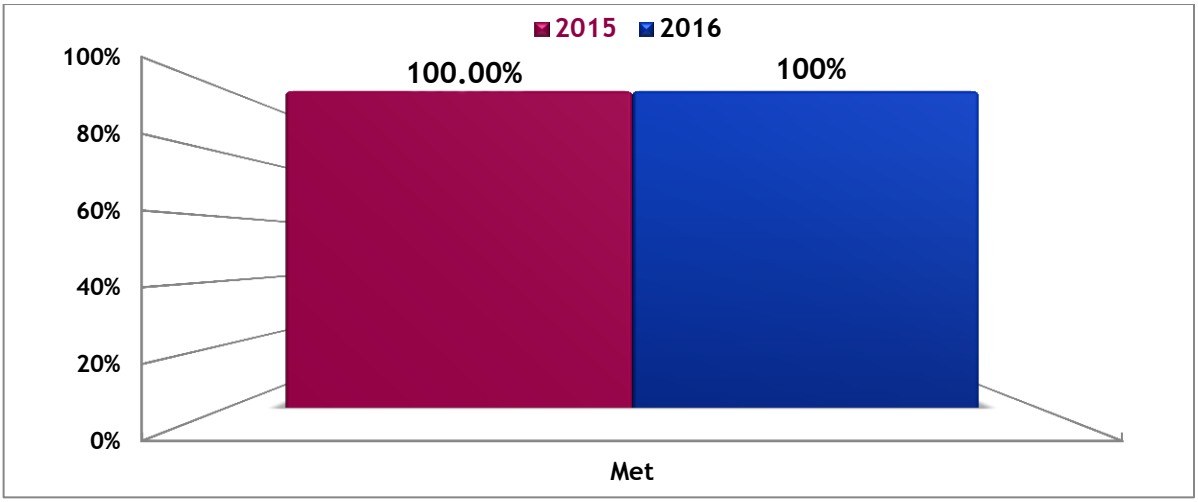
ATC has an experienced leadership team led by Plan President and CEO Paul Accardi. There appears to be sufficient staff in all departments for ATC to meet their members' health care needs. Dr. Robert Thompson is the medical director and an open position for another full-time medical director was recently filled. There are three part-time physician consultants.

The *Compliance and Ethics Program Description* and a *Fraud, Waste, and Abuse Plan* are in place, and include appropriate training for the plan president, directors, providers, employees, and external vendors. The Compliance Committee meets on a quarterly and ad hoc basis. Good attendance and quorums were documented in the minutes of each committee meeting. Fraud, waste, and abuse hotline phone numbers are documented in the *Provider Manual*, *Member Handbook*, and the ATC website. Fraud, waste, and abuse hotline phone numbers are also included in employee information, and prominently posted in the workplace.

ATC/Centene's well-documented *Disaster Recovery Plan* was last tested in May 2016. ATC's *Disaster Recovery Plan* is thorough, and provides staff with extensive contact and location information that would be critical in a recovery situation. The *Disaster Recovery Test Report* indicates that ATC/Centene was able to satisfy the requirements needed to restart operations should a disaster occur. The plan meets the organization's internal requirements and surpasses the MCO contract requirements by completing more than 99% of clean claims in 30 days and 100% of clean claims within 90 days.

Figure 2, Administration Findings, indicates ATC received a "Met" score for all of the standards in the Administration section. In fact, they have Met 100% of the standards in this area for the past three years.

Figure 2: Administration Findings



Strengths

- ATC has an established and knowledgeable leadership team and staffing that is sufficient to provide the required services to its members.
- ATC/Centene's yearly operations audit does a good job of summarizing the controls implemented around claims processing systems.
- The Compliance and Ethics Program, and Fraud, Waste and Abuse Plan meet contract requirements and demonstrate ATC's commitment to program integrity by conducting audits, routine monitoring, and reporting any identified noncompliance.

B. Provider Services

The Credentialing Committee is chaired by Medical Director Dr. Shalini Mittal. Additional voting members of the committee include Medical Director Dr. Robert Thompson and three network providers with the specialties of pediatrics and surgery. *Policy CC.CRED.03, Credentialing Committee*, defines the composition, responsibilities, and meeting protocols. The committee meets monthly and reports to the Quality Improvement Committee (QIC) quarterly. CCME's review of Credentialing Committee minutes showed good voting member participation. A quorum is met with 2/3 of the voting members in attendance and meeting minutes reflect that a quorum is established at each meeting. Onsite discussion revealed that a network physician with a specialty of surgery is currently being added to the Credentialing Committee.

Procedures for network selection and retention are defined in several credentialing policies. The policies are detailed and address specific state requirements in the

footnotes and attachments. The credentialing and recredentialing file review showed the files were organized and, for the most part, contained appropriate documentation. However, several organizational provider files did not contain proof of query for the *SC Excluded Providers List*. A few recommendations were made because one credentialing nurse practitioner file did not contain the required written protocols, and one recredentialing file did not have proof of query for the National Plan and Provider Enumeration System (NPPES).

A few policy updates were identified that are discussed in the "Weaknesses" section that follows.

Provider Access and Availability Study

As a part of the annual EQR process for ATC, CCME performed a provider access study that focused on primary care providers (PCPs). Using the ATC-provided list of current providers, CCME identified a population of 1,800 unique PCPs. Next, a sample of 300 providers was selected from this population for the access study. Attempts were made to contact these providers to ask them a series of questions regarding the access members have to the contracted providers.

Calls were successfully answered 43% of the time by personnel at the correct practice, which estimates to between 40 and 45% for the entire population. When compared to last year's results of 52%, this year's study proportion decreased from the previous measure, and represents a statistically significant decrease.

For those not answered successfully, 25% of the time (estimates to 23 to 27% for the entire population) the caller was informed that provider was not at that office or phone number. Of the successful calls, 90% (estimates to 88 to 93% for the entire population) of the providers indicated they specifically accept ATC as a health plan. Of those that indicated they accept the plan, 63% (estimates to 58 to 67 for the entire population) of the providers responded they are accepting new Medicaid patients.

When asked about any screening process for new patients, 35% (estimates to 30 to 40% for the entire population) indicated that an application or prescreen was necessary. Fifty % (estimates to 40 to 60% for the entire population) of those with a prescreening process requires both an application and review of the medical record before accepting the patient. When the office was asked about the next available routine appointment, 72% (estimates to 67 to 77% for the entire population) of the appointment answers met within contract requirements.

Figure 3, Provider Services Findings, shows that 95 % of the standards in Provider Services received a "Met" score. *Table 2, Provider Services Comparative Data,* highlights standards that showed a change in score from 2015 to 2016.

Figure 3: Provider Services Findings

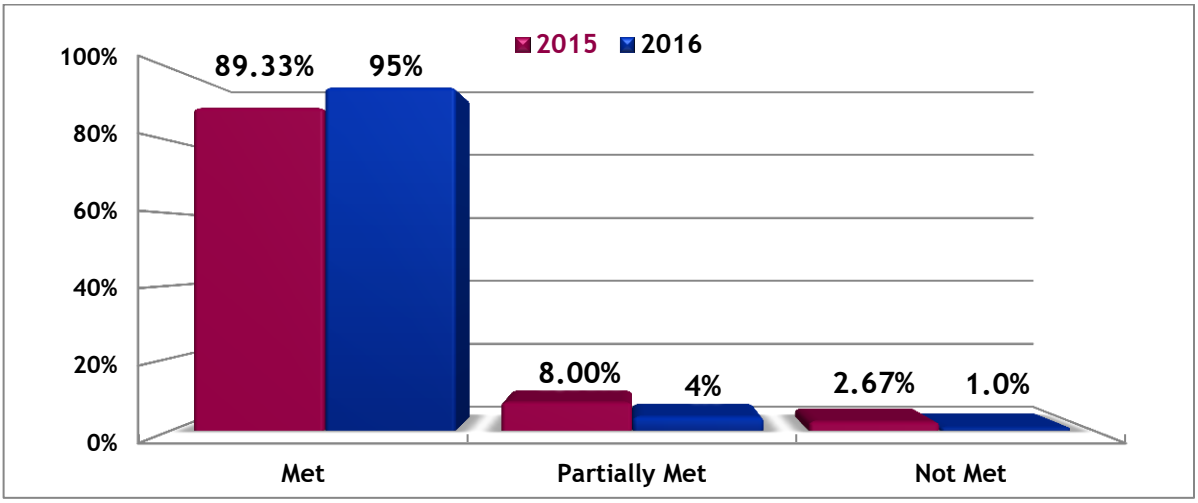


Table 2: Provider Services Comparative Data

SECTION	STANDARD	2015 REVIEW	2016 REVIEW
Credentialing and Recredentialing	The MCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in manner consistent with contractual requirements	Partially Met	Met
	Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the MCO	Partially Met	Met
	Recredentialing: Ownership Disclosure form	Not Met	Met
	Site reassessment if the provider location has changed since the previous credentialing activity	Met	Partially Met
Adequacy of the Provider Network	Members have a primary care physician located within a 30-mile radius of their residence	Met	Partially Met

SECTION	STANDARD	2015 REVIEW	2016 REVIEW
Adequacy of the Provider Network	The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually	Partially Met	Met
	The MCO maintains a provider directory that includes all requirements outlined in the contract	Partially Met	Met
	The MCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2015 to 2016.

Strengths

- ATC implemented a new process where provider demographic updates can easily be made locally and they feel this should help improve the accuracy of the provider demographic data.
- The *Provider Manual* is detailed and is a good resource for understanding ATC's processes.

Weaknesses

- The credentialing and recredentialing file review reflected the following:
    - One credentialing nurse practitioner file did not contain proof of written protocols.
    - One recredentialing file did not contain proof of search for the NPPES.
    - Three organizational credentialing files did not contain proof of query for the *SC Excluded Providers List*.
- *Attachment J of Policy CC.CRED.05, Practitioner Office Site Review*, incorrectly states that ATC must complete site visits within 45 calendar days of the complaint threshold being met regarding the quality of the provider's office. Onsite discussion confirmed the timeframe is now 60 calendar days.
- Table 1 in *Policy SC.QI.04, Quality Improvement Evaluation of Practitioner's Availability*, incorrectly states that standards by PCP type include at least two family practitioners (FPs) or general practitioners (GPs) within 30 miles. Onsite discussion confirmed it should reflect the standard of one FP or GP within 30 miles.

- The *Telephonic Provider Access Study* conducted by CCME revealed a statistically significant decrease when compared to last year's results (from 52% previous review to 43% this review).

Quality Improvement Plans

- Update *Attachment J of Policy CC.CRED.05, Practitioner Office Site Review*, to reflect the 60-day timeframe being used by ATC for site visits as a result of a complaint threshold being met regarding the provider's office.
- Ensure proof of query of the *SC Excluded Providers List* is in the credentialing and recredentialing files.
- Correct Table 1 in *Policy SC.QI.04, Quality Improvement Evaluation of Practitioner's Availability*, to reflect the access standard of at least one FP or GP within 30 miles.
- Regarding members' access to their providers, look for barriers in the update process for provider contact information and conduct data checks for accuracy of provider contact information.

Recommendations

- Ensure written protocols are collected for all nurse practitioners being credentialed.
- Ensure proof of query for the NPPES is in the credentialing/recredentialing files.

C. Member Services

The review of Member Services included a review of all policies, procedures, member rights, member education, and processes for handling grievances, disenrollment, and requests for practitioner changes. New members receive a packet of information that includes the *Member Handbook*, an introductory letter, identification card, and how to request information about providers or request a printed *Provider Directory*. The *Member Handbook* includes Member Rights and Responsibilities and the Notice of Privacy Practices. Information is presented in an easily understood format, and is available in Spanish and in alternate formats upon request. The *Member Handbook* would be enhanced by providing members with additional information on Advance Directives.

ATC is proactive about educating and encouraging members to obtain preventive health screenings and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) well-child visits by sending frequent reminders such as birthday card and postcards, by member outreach phone calls, and helping members to overcome barriers to care. Providers receive *Gaps in Care Reports* to encourage direct outreach from PCPs. ATC is also in the process of developing a program to address the serious issue of substance abuse in pregnant women.

A review of ATC's grievance policy and processes showed improvement over last year by providing employees, members, and provider's consistent information about the grievance process in handbooks and policies. Grievance files reflected timely acknowledgement and timely resolution, with one exception. Several files revealed a weakness in documenting all the steps taken to resolve a grievance. Onsite discussion indicated ATC took appropriate actions to refer the grievance to other departments; however, the files did not reflect all the conducted communications. Appropriate referrals were made internally to Provider Services and Quality when needed, but again the files lacked documentation of the actions taken to resolve the grievance. In addition, CCME could not identify a clearly defined process explaining that member requests for a change of PCP due to dissatisfaction are handled as grievances.

SPH Analytics, an NCQA certified vendor, conducted the Member Satisfaction child and adult Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. The results of the surveys were shared with the QIC, plan members and providers.

Figure 4: Member Services Findings, shows that 95% of the standards for Member Services were scored as "Met." Scores of "Partially Met" were due to a lack of policies that addressed who would make decisions on grievances regarding the denial of expedited appeal, and that dissatisfaction with PCPs resulting in a member's request to change PCPs are handled as grievances. Incomplete grievance file documentation was also scored as "Partially Met." *Table 3: Member Services Comparative Data,* highlights standards that showed a change in score from 2015 to 2016.

Figure 4: Member Services Findings

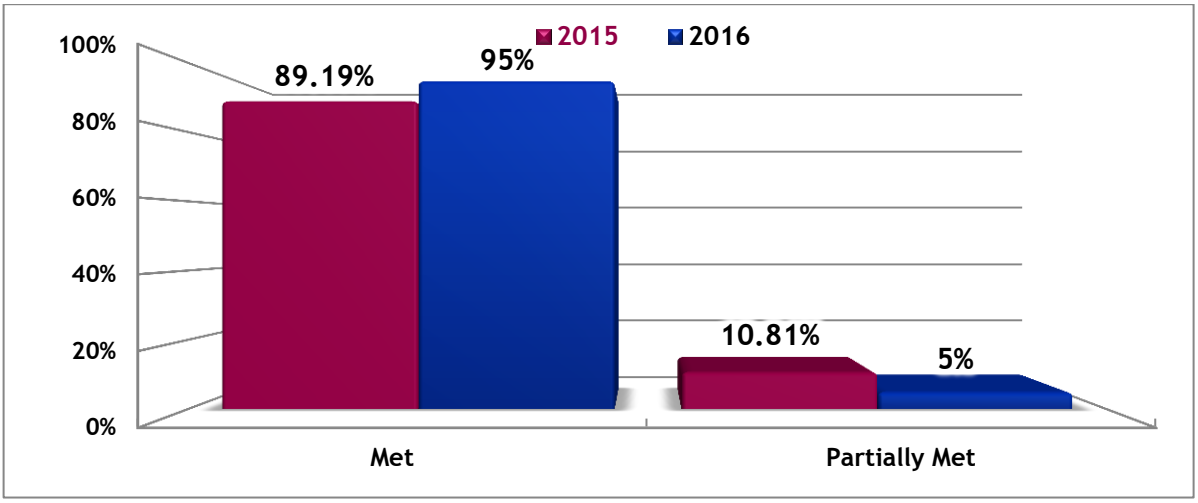


Table 3: Member Services Comparative Data

SECTION	STANDARD	2015 REVIEW	2016 REVIEW
Member MCO Program Education	Members are informed in writing within 14 business days of enrollment of all benefits to which they are contractually entitled	Partially Met	Met
Grievances	The procedure for filing and handling a grievance	Partially Met	Met
	Timeliness guidelines for resolution of the grievance as specified in the contract	Partially Met	Met
	Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2015 to 2016.

Strengths

- The *Member Handbook* presents all the required member information and is written in an easily understood manner.
- ATC uses a variety of methods to keep members informed about adult preventive health screenings and well-child visits conducted at appropriate intervals.
- To their credit, ATC is in the process of developing a program to address substance abuse in pregnant women.

Weaknesses

- During onsite discussion, it was revealed that the statement in the list of member responsibilities found in various documents, "To choose a person to act on their behalf" is referring to a member allowing someone to speak for them during a phone conversation with ATC. This is an option for members and not a responsibility.
- The *Member Handbook*, page 16, states there is a copayment of $3.40 for Behavioral Health & Alcohol, Drug and Substance Abuse (outpatient); however, this copayment is not found on the website.
- Minimum information on Advance Directives is found in the *Member Handbook*.
- Target rates for responses to CAHPS surveys were lower than 40%.
- *Policy SC.UM.11, Member Grievances*, states grievances that involve clinical issues will be reviewed by a health care professional who has the appropriate expertise, as determined by the State, in treating the members' condition or disease. The policy

does not indicate that the same reviewer expertise also applies to those who make decisions on grievances related to the denial of a request for an expedited appeal.

- Grievance files reflected appropriate referrals to other departments; however, steps taken by other departments to resolve the grievances were not always documented in the grievance files.
- The process of recording requests for PCP changes due to dissatisfaction as grievances was not found in *Policy SC.MBRS.02, PCP Change/Selection, Policy SC.UM.11, Member Grievances*, or any other document.

Quality Improvement Plans

- Include in *Policy SC.UM.11, Member Grievances,* that a grievance regarding the denial of expedited resolution of an appeal will be decided by a health care professional with appropriate clinical expertise, as determined by the State, in treating the Medicaid managed care member's condition or disease.
- Ensure the template used to document grievance resolution includes a place for each employee or department to document actions taken and contacts made in the process of resolving a grievance.

Recommendations

- Update the language in the following documents to clearly explain the intent of the responsibility "To choose a person to act on their behalf." Consider moving this to the list of rights instead of responsibilities because members can do so if they choose but do not have a responsibility to do this:
    - *Policy SC.MBRS.25, Member Rights and Responsibilities*
    - The *Provider Manual*
    - The *Member Handbook* and
    - The ATC website.
- Update the copay information on the website to include the correct copayment for services for Behavioral Health & Alcohol, Drug and Substance abuse (outpatient).
- Include in the *Member Handbook* who can assist members to formulate and execute an advance directive. Consider developing a brochure that could be sent to members requesting additional information.
- Implement strategies to increase response rates for both adult and child CAHPS surveys. Work with your vendor to find ways to reach more respondents.
- Develop a new policy or include in an active policy ATC's process to file a grievance when a member requests to change their PCP due to dissatisfaction. Define how this information is used to identify opportunities for improvement.

D. Quality Improvement

ATC's 2016 *Quality Assessment and Performance Improvement Program Description* outlines the program the health plan has in place to monitor, analyze, evaluate, and improve the health care provided to all members.

The medical directors have an active role in the Quality Improvement program. ATC has two full-time medical directors and three medical director consultants. Dr. Robert Thompson provides overall direction and oversight of all clinical and service quality improvement initiatives.

Page 17 of the program description discusses continuity of care and mentions the process followed when a member is affected by the termination of a provider. The timeframe for notifying a member of this termination is incorrect. According to *Policy SC.ELIG.14, Member Notification of Provider Termination,* and *42 CFR § 438.10 (f)*, the health plan must make a good faith effort to give written notice of termination of a contracted provider within 15 days after receipt of the termination notice.

ATC has established a committee structure with various subcommittees and ad-hoc committees responsible for monitoring and supporting the quality improvement activities and programs. The Quality Improvement Committee (QIC) provides oversight and directions in assessing the appropriateness of care and service delivery provided to members.

The effectiveness of the program is evaluated annually. Results are reported to the QIC and the Board of Directors for approval. The *Quality Assessment and Performance Improvement Program Evaluation* for 2015 and the Cenpatico 2015 *Quality Improvement Program Evaluation* were provided in the desk materials. Both program evaluations provided an assessment of the accomplishments for 2015.

Performance Measure Validation

CCME conducted a validation review of the Health Effectiveness Data Information Set (HEDIS®) performance measures following CMS developed protocols. This process assesses the production of these measures by the health plan to confirm reported information is valid.

ATC uses Inovalon, a certified software organization, to calculate HEDIS rates and verify the measures are fully compliant and consistent with CMS protocol requirements. The HEDIS rates show a decline in childhood immunization for most of the measures, with two of the measures decreasing more than 10% from the previous year. Further evaluation of the reasons for these decreases is warranted. All relevant HEDIS performance measures are detailed in *Table 4: HEDIS Performance Measure Data*.

Table 4: HEDIS Performance Measure Data

MEASURE/DATA ELEMENT	HEDIS 2014	HEDIS 2015	PERCENTAGE POINT DIFFERENCE
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (aba)	68.06%	77.38%	+9.32%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	45.37%	58.89%	+13.52%
Counseling for Nutrition	46.30%	46.88%	+0.58%
Counseling for Physical Activity	42.36%	37.50%	-4.86%
Childhood Immunization Status (cis)			
DTaP	75.46%	70.36%	-5.10%
IPV	87.50%	85.78%	-1.72%
MMR	89.58%	84.34%	-5.24%
HiB	85.19%	80.24%	-4.95%
Hepatitis B	86.57%	85.78%	-0.79%
VZV	90.97%	84.58%	-6.39%
Pneumococcal Conjugate	77.55%	68.43%	-9.12%
Hepatitis A	84.26%	75.66%	-8.60%
Rotavirus	71.76%	66.99%	-4.77%
Influenza	42.36%	32.29%	-10.07%
Combination #2	70.14%	63.86%	-6.28%
Combination #3	68.29%	60.24%	-8.05%
Combination #4	64.81%	56.39%	-8.42%
Combination #5	57.64%	49.16%	-8.48%
Combination #6	36.57%	26.51%	-10.06%
Combination #7	55.56%	47.47%	-8.09%
Combination #8	35.88%	26.51%	-9.37%
Combination #9	32.41%	23.37%	-9.04%
Combination #10	31.71%	23.37%	-8.34%
Immunizations for Adolescents (ima)			
Meningococcal	63.19%	66.59%	+3.40%
Tdap/Td	84.26%	87.02%	+2.76%
Combination #1	62.73%	66.11%	+3.38%
Human Papillomavirus Vaccine for Female Adolescents (hpv)	16.90%	20.67%	+3.77%
Lead Screening in Children (lsc)	65.74%	55.53%	-10.21%
Breast Cancer Screening (bcs)	59.91%	59.37%	-0.54%
Cervical Cancer Screening (ccs)	64.25%	64.55%	+0.30%
Chlamydia Screening in Women (chl)			
16-20 Years	52.92%	51.02%	-1.90%
21-24 Years	63.06%	63.71%	+0.65%
Total	56.11%	55.16%	-0.95%
Effectiveness of Care: Respiratory Conditions			

MEASURE/DATA ELEMENT	HEDIS 2014	HEDIS 2015	PERCENTAGE POINT DIFFERENCE
Appropriate Testing for Children with Pharyngitis (cwp)	69.21%	70.27%	+1.06%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	26.71%	21.59%	-5.12%
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	48.94%	51.51%	+2.57%
Bronchodilator	74.65%	81.33%	+6.68%
Medication Management for People With Asthma (mma)			
5-11 Years - Medication Compliance 50%	40.58%	42.33%	+1.75%
5-11 Years - Medication Compliance 75%	14.13%	18.99%	+4.86%
12-18 Years - Medication Compliance 50%	39.38%	41.26%	+1.88%
12-18 Years - Medication Compliance 75%	16.71%	15.76%	-0.95%
19-50 Years - Medication Compliance 50%	51.79%	47.89%	-3.90%
19-50 Years - Medication Compliance 75%	23.21%	26.76%	+3.55%
51-64 Years - Medication Compliance 50%	56.76%	69.44%	+12.68%
51-64 Years - Medication Compliance 75%	32.43%	22.22%	-10.21%
Total - Medication Compliance 50%	41.94%	43.60%	+1.66%
Total - Medication Compliance 75%	16.60%	19.07%	+2.47%
Asthma Medication Ratio (amr)			
5-11 Years	65.19%	67.93%	+2.74%
12-18 Years	53.45%	53.67%	+0.22%
19-50 Years	48.30%	42.70%	-5.60%
51-64 Years	50.00%	60.42%	+10.42%
Total	58.52%	59.30%	+0.78%
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (cbp)	41.56%	43.58%	+2.02%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	NA	60.00%	NA
Statin Therapy for Patients With Cardiovascular Disease (spc)			
Received Statin Therapy - 21-75 years (Male)	NA	70.00%	NA
Statin Adherence 80% - 21-75 years (Male)	NA	60.39%	NA
Received Statin Therapy - 40-75 years (Female)	NA	64.10%	NA
Statin Adherence 80% - 40-75 years (Female)	NA	61.00%	NA
Received Statin Therapy - Total	NA	67.55%	NA
Statin Adherence 80% - Total	NA	60.63%	NA
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)			
Hemoglobin A1c (HbA1c) Testing	82.71%	85.65%	+2.94%
HbA1c Poor Control (>9.0%)	55.65%	52.55%	-3.10%
HbA1c Control (<8.0%)	35.92%	39.81%	+3.89%
HbA1c Control (<7.0%)	NR	NR	NR
Eye Exam (Retinal) Performed	40.80%	51.39%	+10.59%
Medical Attention for Nephropathy	78.94%	90.97%	+12.03%

MEASURE/DATA ELEMENT	HEDIS 2014	HEDIS 2015	PERCENTAGE POINT DIFFERENCE
Blood Pressure Control (<140/90 mm Hg)	44.35%	43.06%	-1.29%
Statin Therapy for Patients With Diabetes (spd)			
Received Statin Therapy	NA	54.89%	NA
Statin Adherence 80%	NA	40.06%	NA
Effectiveness of Care: Musculoskeletal Conditions			
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	65.52%	59.26%	-6.26%
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	37.56%	36.20%	-1.36%
Effective Continuation Phase Treatment	22.21%	22.63%	+0.42%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	50.45%	50.16%	-0.29%
Continuation and Maintenance (C&M) Phase	61.11%	64.32%	+3.21%
Follow-Up After Hospitalization for Mental Illness (fuh)			
30-Day Follow-Up	63.10%	62.36%	-0.74%
7-Day Follow-Up	42.60%	40.68%	-1.92%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	73.43%	75.00%	+1.57%
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	67.11%	63.64%	-3.47%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)	NA	61.54%	NA
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	56.50%	55.15%	-1.35%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
1-5 Years	NA	NA	NA
6-11 Years	18.26%	17.59%	-0.67%
12-17 Years	22.22%	22.67%	+0.45%
Total	20.21%	20.49%	+0.28%
Effectiveness of Care: Medication Management			
Annual Monitoring for Patients on Persistent Medications (mpm)			
ACE Inhibitors or ARBs	88.10%	87.98%	-0.12%
Digoxin	44.12%	48.48%	+4.36%
Diuretics	88.50%	88.59%	+0.09%
Total	87.82%	87.89%	+0.07%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	5.35%	4.29%	-1.06%
Appropriate Treatment for Children With URI (uri)	84.12%	84.79%	+0.67%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	23.08%	21.53%	-1.55%
Use of Imaging Studies for Low Back Pain (lbp)	73.92%	70.51%	-3.41%

MEASURE/DATA ELEMENT	HEDIS 2014	HEDIS 2015	PERCENTAGE POINT DIFFERENCE
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (apc)			
1-5 Years	NR	NR	NA
6-11 Years	NR	NR	NA
12-17 Years	NR	NR	NA
Total	NR	NR	NA
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)			
20-44 Years	80.58%	80.24%	-0.34%
45-64 Years	86.94%	87.29%	+0.35%
65+ Years	NA	50.00%	NA
Total	82.44%	82.45%	+0.01%
Children and Adolescents' Access to Primary Care Practitioners (cap)			
12-24 Months	93.88%	96.21%	+2.33%
25 Months - 6 Years	84.26%	86.28%	+2.02%
7-11 Years	89.44%	87.91%	-1.53%
12-19 Years	87.28%	86.56%	-0.72%
Initiation and Engagement of AOD Dependence Treatment (iet)			
Initiation of AOD Treatment: 13-17 Years	43.58%	33.96%	-9.62%
Engagement of AOD Treatment: 13-17 Years	21.23%	17.61%	-3.62%
Initiation of AOD Treatment: 18+ Years	37.46%	36.36%	-1.10%
Engagement of AOD Treatment: 18+ Years	6.99%	6.58%	-0.41%
Initiation of AOD Treatment: Total	38.03%	36.18%	-1.85%
Engagement of AOD Treatment: Total	8.33%	7.43%	-0.90%
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	93.29%	90.28%	-3.01%
Postpartum Care	64.58%	71.56%	+6.98%
Call Answer Timeliness (cat)	88.85%	90.41%	+1.56%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
1-5 Years	NR	NR	NA
6-11 Years	62.75%	70.18%	+7.43%
12-17 Years	45.59%	55.13%	+9.54%
Total	54.10%	61.03%	+6.93%
Utilization			
Frequency of Ongoing Prenatal Care (fpc)			
<21 Percent	2.55%	2.37%	-0.18%
21-40 Percent	3.01%	2.37%	-0.64%
41-60 Percent	6.25%	5.21%	-1.04%
61-80 Percent	12.27%	12.80%	+0.53%
81+ Percent	75.93%	77.25%	+1.32%
Well-Child Visits in the First 15 Months of Life (w15)			
0 Visits	1.16%	0.72%	-0.44%
1 Visit	2.78%	1.93%	-0.85%
2 Visits	4.63%	3.38%	-1.25%

MEASURE/DATA ELEMENT	HEDIS 2014	HEDIS 2015	PERCENTAGE POINT DIFFERENCE
3 Visits	4.17%	5.31%	+1.14%
4 Visits	10.88%	8.21%	-2.67%
5 Visits	14.81%	20.53%	+5.72%
6+ Visits	61.57%	59.90%	-1.67%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	58.33%	59.38%	+1.05%
Adolescent Well-Care Visits (awc)	39.58%	46.88%	+7.30%

Performance Improvement Project Validation

CCME validated ATC's Performance Improvement Projects (PIPs) in accordance with the CMS-developed protocol titled, "EQR Protocol 3: Validating Performance Improvement Projects Version 2.0, September 2012." The protocol validates project components and its documentation to provide an assessment of the overall study design and project methodology. The components assessed are as follows:

- Study topic(s)
- Study question(s)
- Study indicator(s)
- Identified study population
- Sampling methodology (if used)
- Data collection procedures
- Improvement strategies

CCME validated two projects using the CMS Protocol for Validation of Performance Improvement Projects. They included Diabetic Eye Exam and Member Satisfaction. *Table 5, Performance Improvement Project Validation Scores,* includes the scores and results for each PIP.

TABLE 5: Performance Improvement Project Validation Scores

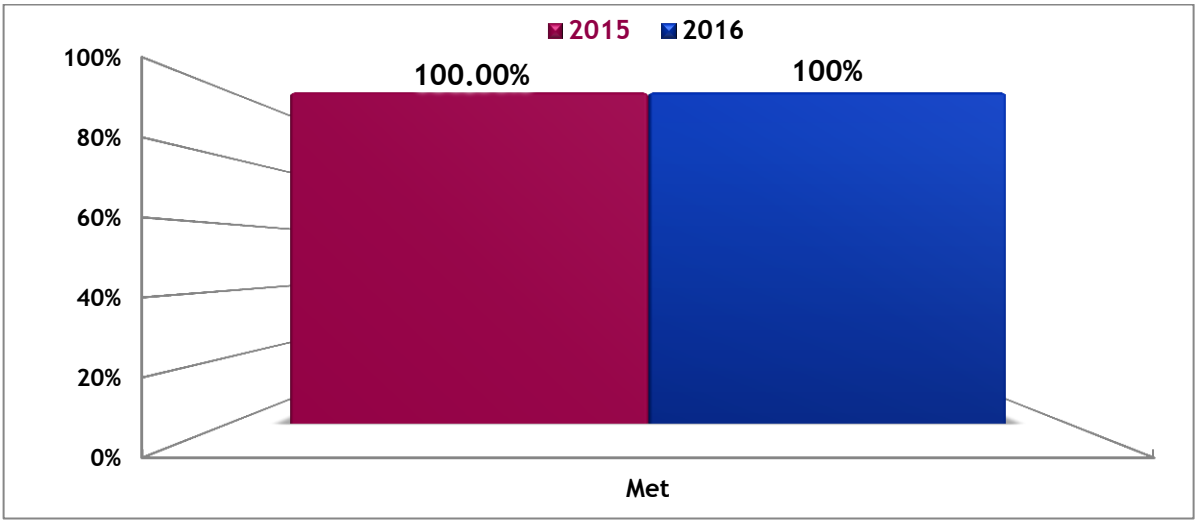
PROJECT	2015 VALIDATION SCORE	2016 VALIDATION SCORE
Diabetic Eye Exam	98 / 98 = 100% HIGH CONFIDENCE	131/131 = 100% HIGH CONFIDENCE
Member Satisfaction	98 / 98 = 100% HIGH CONFIDENCE	125 / 125 = 100% HIGH CONFIDENCE

Both projects had a justified rationale using analysis of data, and the research questions were stated clearly. Furthermore, documentation was well-organized and results were

presented clearly and accurately. Interventions were applicable to the project goals. Details of the validation of the performance measures and performance improvement projects may be found in the *CCME EQR Validation Worksheets, Attachment 3*.

All of the standards were met in the Quality Improvement section as shown in *Figure 5: Quality Improvement Findings*.

Figure 5: Quality Improvement Findings



Strengths

- ATC uses NCQA certified software for HEDIS calculations.
- PIPs are sound methodologically and documentation is well-organized and clear. Both projects scored within the *High Confidence* range.

Weaknesses

- The timeframe for notifying a member of this termination is incorrect on page 17 of the *Quality Improvement Program Description*. According to *Policy SC.ELIG.14, Member Notification of Provider Termination*, and *42 CFR § 438.10 (f)*, the health plan must make a good faith effort to give written notice of termination of a contracted provider within 15 days after receipt of the termination notice. The program description lists the timeframe as 30 calendar days.
- The HEDIS rates show a decline in childhood immunization for most of the measures, with two of the measures decreasing more than 10% from the previous year.

Recommendation

- Correct the timeframe for notifying affected members of a terminated provider in the *Quality Improvement Program Description*.

- Further evaluation to determine the reason for the decline in the childhood immunization rates is warranted.

E. Utilization Management

ATC's *UM Program Description*, *CM Program Description*, and *Pharmacy Program Description*, along with departmental policies, define UM requirements and processes, and guide staff in the performance of UM and CM functions. The medical director, Dr. Robert Thompson, oversees and supports the UM Program. Jenna Meisner, RPh, oversees pharmacy services activities. Cenpatico is responsible for all behavioral health and substance abuse aspects of the UM Program. A medical director specializing in psychiatry oversees Cenpatico's UM activities.

The *SCDHHS Contract, Section 8.4.2.7*, requires the health plans to develop and implement a Preferred Provider Program. *Policy SC.UM.54, Preferred Provider Designation*, explains ATC's criteria for providers to achieve the Preferred Provider Designation through consistent management of care based on quality and practice guidelines. Preferred Status exempts providers from prior authorization requirements, allows expedited prior authorization processing, and/or simplifies documentation requirements for prior authorization requests. Onsite discussion revealed that one provider has achieved the Preferred Status designation, and ATC is evaluating additional providers for inclusion in the program.

ATC uses InterQual Level of Care Criteria along with Centene Medical Policies to make medical necessity determinations for authorization requests. Consistency of application of criteria is monitored by annual inter-rater reliability (IRR) testing of all staff involved in medical necessity decision-making. The most recent IRR testing resulted in all but four staff scoring at or above the benchmark of 90%. The four staff members scoring less than 90% were retested, resulting in passing scores. IRR results are reported to all ATC leadership and to the QIC. CCME's review of UM approval and denial files confirmed that ATC uses appropriate criteria for medical necessity determinations.

Appeals processes are generally well-documented in policies, the *Member Handbook*, and *Provider Manual*; however, *Policy SC.UM.13, Member Appeals*, does not define which staff members are allowed to render a determination that an expedited appeal request does not meet criteria for an expedited resolution timeframe. Onsite discussion confirmed that only a medical director can render a determination to downgrade an appeal from expedited to standard resolution status. CCME's appeals file review confirmed that ATC follows appropriate processes for review, resolution, and notification of appeals determinations.

As indicated in *Figure 6: Utilization Management Findings*, 97% of the standards in the UM section were scored as "Met." The score of "Partially Met" was related to lack of information in the Member Appeals policy regarding who is allowed to downgrade an appeal from an expedited to a standard resolution timeframe. *Table 6: Utilization Management Comparative Data* highlights standards that showed a change in score from 2015 to 2016.

Figure 6: Utilization Management Findings

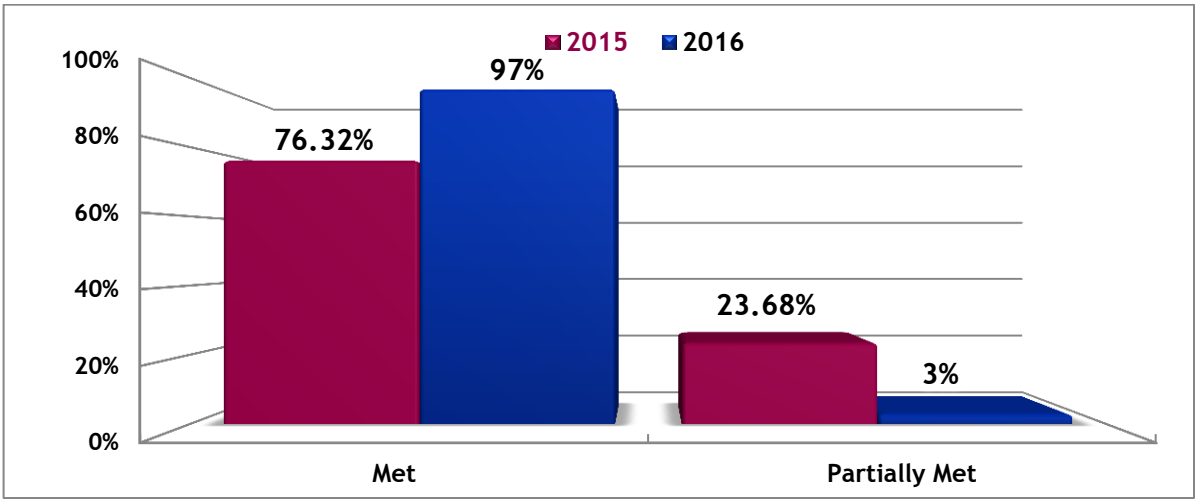


TABLE 6: Utilization Management Comparative Data

SECTION	STANDARD	2015 REVIEW	2016 REVIEW
The Utilization Management (UM) Program	The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to timeliness of UM decisions, initial notification, and written (or electronic) verification	Partially Met	Met
	The mechanism to provide for a preferred provider program	Partially Met	Met
Medical Necessity Determinations	Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations	Partially Met	Met
	Utilization management standards/criteria are available to providers.	Partially Met	Met

SECTION	STANDARD	2015 REVIEW	2016 REVIEW
Medical Necessity Determinations	Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal.	Partially Met	Met
Appeals	The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an action by the MCO in a manner consistent with contract requirements, including the procedure for filing an appeal	Partially Met	Met
	Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case	Partially Met	Met
	A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay	Met	Partially Met
	Timeliness guidelines for resolution of the appeal as specified in the contract	Partially Met	Met
	Written notice of the appeal resolution as required by the contract	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2015 to 2016.

Strengths

- ATC is working to increase the availability of providers for pediatric behavioral health services and to increase the number of providers willing to participate in pediatric behavioral health case management programs.
- ATC has successfully implemented a Preferred Provider Program according to contractual requirements and continues to evaluate providers for inclusion in the program.
- The percentage of EQR UM standards receiving a score of "Met" increased from 76.32% for the 2015 review to 97% for the 2016 review.

Weaknesses

- A discrepancy in documentation of the timeframe for requesting prior authorization was noted:
    - ATC's website states prior authorization requests should be submitted at least 5 business days before the scheduled service delivery date.
    - *Policy SC.UM.05, Timeliness of UM Decisions and Notifications*, page one, states prior authorization must be requested within 10 days prior to the requested service date.
- *Policy SC.UM.13, Member Appeals*, describes requirements and processes for expedited appeals, and states ATC will review a request for an expedited appeal to determine if the request involves an imminent and/or serious threat to the health of the member. The policy does not define which staff members are allowed to make this determination. Onsite discussion confirmed that only medical directors issue a determination to deny an expedited appeal timeframe.

Quality Improvement Plan

- Revise *Policy SC.UM.13, Member Appeals*, to define which staff members are allowed to make the determination to deny an expedited appeal timeframe.

Recommendations

- Revise *Policy SC.UM.05, Timeliness of UM Decisions and Notifications*, to indicate prior authorization must be requested at least 5 business days before the scheduled service delivery date.

F. Delegation

ATC's delegation process includes obtaining written delegation agreements for all delegated entities. The delegation agreements specify the functions delegated and include information on oversight, monitoring, and corrective action for substandard performance of delegated functions. *Table 7: Delegated Entities and Services,* shows ATC's delegated entities and services.

Table 7: Delegated Entities and Services

Delegated Entities	Delegated Services
Envolve PeopleCare / Cenpatico	Behavioral Health - Utilization Management (UM); Claims Adjudication; Credentialing/ Recredentialing; Network Development & Maintenance; Case Management
National Imaging Associates (NIA)	Radiology - UM; Credentialing/Recredentialing; Network Development & Maintenance
Envolve People Care (Legacy Nutur & NurseWise)	Disease Management merged with Nurse Hotline effective 4/1/16
Envolve Benefit Options (OptiCare)	Vision - Claims Adjudication; Credentialing/ Recredentialing; Network Development & Maintenance
Envolve Pharmacy (USScript)	Pharmacy Benefit Management - UM; Claims Adjudication; Network Development & Maintenance
CHS – Mary Black; Greenville Health Systems; Medical College of Georgia (MCG/PPG); MUSC – Medical University of South Carolina; St. Francis Physician Services, Inc.; University of South Carolina University Specialty Clinics; CVS Health Minute Clinic; Preferred Care of Aiken; Health Network Solutions (HNS)	Credentialing/Recredentialing

Policy SC.COMP.14, Oversight of Delegated Vendors, defines the procedures for evaluating an entity's capability to perform delegated activities prior to a delegation agreement, the requirements for implementing a written delegation agreement, and reporting and ongoing monitoring of the delegated entities. *Policy CC.CRED.12, Oversight of Delegated Credentialing*, defines the procedures and mechanisms for monitoring the credentialing of practitioner and providers when the authority to perform credentialing activities is delegated to another entity.

ATC retains accountability for delegated services and monitors the performance of delegated entities. ATC conducted annual audits and implemented quality improvement plans when audit results indicated a need. Delegate performance is reported to and monitored by various ATC committees, including the Credentialing Committee and the QIC.

As noted in *Figure 7: Delegation Findings*, both Delegation standards received a "Met" score. *Table 8: Delegation Comparative Data,* highlights one standard that showed a change in score from 2015 to 2016.

Figure 7: Delegation Findings

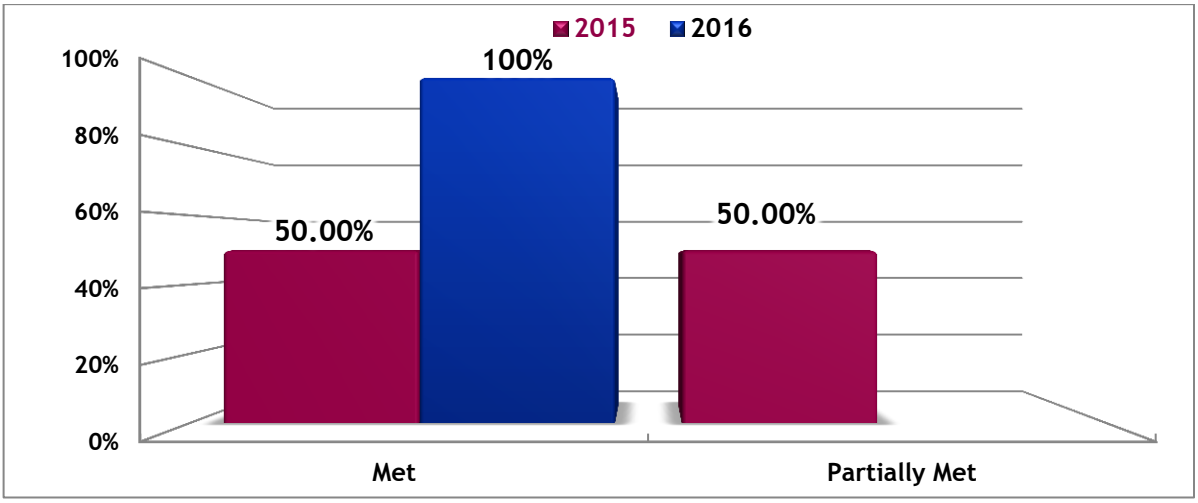


TABLE 8: Delegation Comparative Data

SECTION	STANDARD	2015 REVIEW	2016 REVIEW
Delegation	The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions.	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2015 to 2016.

Strengths

- The delegation oversight process includes annual audits, quarterly oversight by committees, monthly and quarterly review of delegated vendor reports, and initiation of corrective action plans when necessary.

G. State Mandated Services

ATC provides all core benefits required by the *SCDHHS Contract*. EPSDT program requirements are defined in the *EPSDT Program Description*, which is evaluated through the annual Quality Improvement Program evaluation. Providers are required to perform EPSDT medical check-ups in their entirety at the intervals required by the *American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care*.

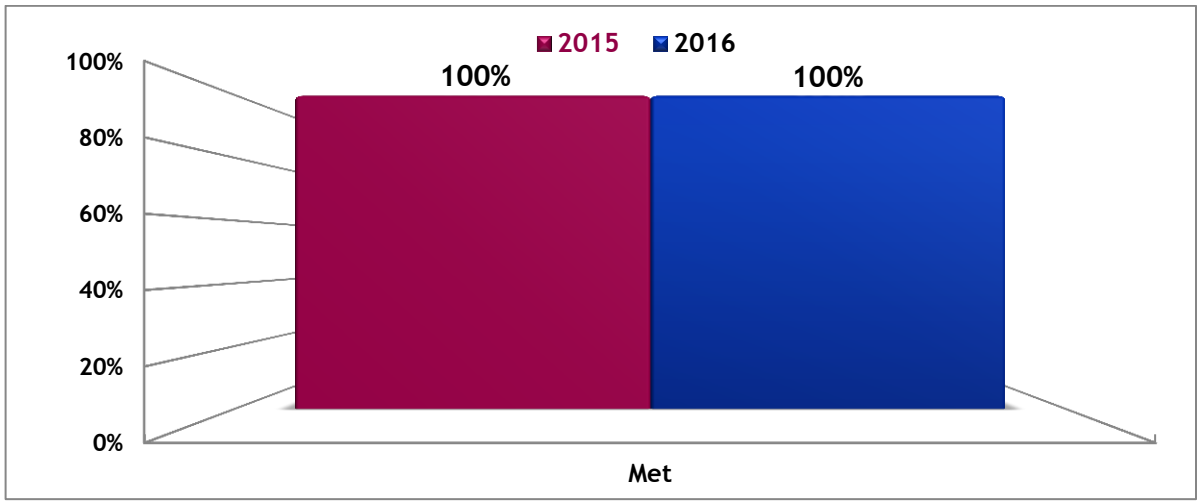
Various methods are used to inform members of available EPSDT services, including the *Member Handbook*, educational mailings, live and auto-dialer calls, care gaps posted to the secure member portal, and through information included in the Start Smart for Your Baby Program.

All examination components, including immunizations, must be documented and included in the medical record of each EPSDT eligible member. Provider compliance is monitored through medical record compliance audits.

CCME's 2016 External Quality Review found that ATC adequately addressed all deficiencies identified in the 2015 External Quality Review.

ATC received a score of "Met" for 100 % of the standards in the State-Mandated Services, as illustrated in *Figure 8: State Mandated Services*.

Figure 8: State Mandated Services



ATTACHMENTS

- Attachment 1: Initial Notice, Materials Requested for Desk Review
- Attachment 2: Materials Requested for Onsite Review
- Attachment 3: EQR Validation Worksheets
- Attachment 4: Tabular Spreadsheet

A. Attachment 1: Initial Notice, Materials Requested for Desk Review

December 05, 2016

Mr. Paul Accardi
President
Absolute Total Care
1441 Main Street, Suite 900
Columbia, SC 29201

Dear Mr. Accardi:

At the request of the South Carolina Department of Health and Human Services (SCDHHS) this letter serves as notification that the 2016 External Quality Review (EQR) of Absolute Total Care is being initiated. An external quality review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) is required by your contract with SCDHHS in relation to your organization's administration of a managed care program for Medicaid recipients.

The methodology used by CCME to conduct this review will follow the protocols developed by the Centers for Medicare and Medicaid Services (CMS) for external quality review of Medicaid Managed Care Organizations. As required by these protocols, the review will include both a desk review (at CCME), onsite visit and will address all contractually required services as well as follow up of any areas of weakness identified during the previous review. The CCME EQR team plans to conduct the onsite visit on **January 26th and 27th.**

In preparation for the desk review, the items on the enclosed desk materials list should be provided to CCME no later than **December 19, 2016.**

Submission of all the desk materials will be different than in the past. This year we have a new secure file transfer website for uploading desk materials electronically to CCME. The file transfer site can be found at:

https://eqro.thecarolinascenter.org

Upon registering with a username and password, you will receive an email with a link to confirm the creation of your account. After you have confirmed the account, CCME will be notified and will send an automated email once the security access has been set up. Please bear in mind that while you will be able to log in to the website after the confirmation of your account, you will see a message indicating that your registration is pending, until CCME grants you the appropriate security clearance. I have included written instructions on how to use the file transfer site and would be happy to schedule an education session (via webinar) on how to utilize the file transfer site if needed. Ensuring successful upload of desk materials is our priority and we value the opportunity to provide support.

An opportunity for a conference call with your staff, to describe the review process and answer any questions prior to the onsite visit, is being offered as well. Please contact me directly at 803-212-7582 if you would like to schedule time for either of these conversational opportunities.

Thank you and we look forward to working with you.

Sincerely,

Sandi Owens

Sandi Owens, LPN
Manager, External Quality Review

Enclosure
cc: SCDHHS

External Quality Review 2016

MATERIALS REQUESTED FOR DESK REVIEW

1. Copies of all current policies and procedures, as well as a complete index which includes policy name, number and department owner. The date of the addition/review/revision should be identifiable on each policy.

2. Organizational chart of all staff members including names of individuals in each position, and any current vacancies.

3. Current membership demographics including total enrollment and distribution by age ranges, sex, and county of residence.

4. Documentation of all service planning and provider network planning activities (e.g., geographic assessments, provider network assessments, enrollee demographic studies, population needs assessments) that support the adequacy of the provider base. Please include the maximum allowed and the current member-to-PCP ratios and member-to-specialist ratios.

5. A complete list of network providers for the Healthy Connections Choices (HCC) members. The list should be submitted as an excel spreadsheet and include the practitioner's name, title (MD, NP, PA etc.), specialty, practice name, address, phone number, counties served, if the provider is accepting new patients, and any age restrictions. Specialty codes and county codes may be used however please provide an explanation of the codes used by your organization. Please note this information will be used to conduct our telephone access study.

6. The total number of unique specialty providers as well as the total number of unique primary care providers currently in the network.

7. A current provider list/directory as supplied to members.

8. A copy of the current Compliance plan.

9. A description of the Credentialing, Quality Improvement, Medical/Utilization Management, Disease/Case Management, and Pharmacy Programs.

10. The Quality Improvement work plans for 2015, and 2016.

11. The most recent reports summarizing the effectiveness of the Quality Improvement, Medical/Utilization Management, and Disease/Case Management Programs.

12. Documentation of all Performance Improvement Projects (PIPs) completed or planned since the previous Annual Review, and any interim information available for those projects currently in progress. This documentation should include information from the project that explains and documents all aspects of the project cycle (i.e. analytic plans, reasons for choosing the topic, measurement definitions, interventions planned or implemented, calculated results, barriers to improvement, results, etc…).

13. Minutes of all committee meetings in the past year reviewing or taking action on SC Medicaid-related activities. All relevant attachments (e.g., reports presented, materials reviewed) should be included. If attachments are provided as part of another portion of this request, a cross-reference is satisfactory, rather than sending duplicate materials.

14. Membership lists and a committee matrix for all committees including the professional specialty of any non-staff members. Please indicate which members are voting members. Please include committee charters if available.

15. Any data collected for the purposes of monitoring the utilization (over and under) of health care services.

16. Copies of the most recent physician profiling activities conducted to measure contracted provider performance.

17. Results of the most recent medical office site reviews, medical record reviews and a copy of the tools used to complete these reviews.

18. A complete list of all members enrolled in the case management program from October 2015 through November 2016. Please include open and closed case management files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for case management.

19. A copy of staff handbooks/training manuals, orientation and educational materials and scripts used by Member Services Representatives and/or Call Center personnel.

20. A copy of the member handbook and any statement of the member bill of rights and responsibilities if not included in the handbook.

21. A report of findings from the most recent member and provider satisfaction survey, a copy of the tool and methodology used. If the survey was performed by a subcontractor, please include a copy of the contract or other documentation of the requested scope of work.

22. A copy of any member and provider newsletters, educational materials and/or other mailings.

23. A copy of the Grievance, Complaint and Appeal logs for the months of October 2015 through November 2016.

24. Copies of all letter templates for documenting approvals, denials, appeals, grievances and acknowledgements.

25. Service availability and accessibility standards and expectations, and reports of any assessments made of provider and/or internal MCO compliance with these standards.

26. Preventive health practice guidelines recommended by the MCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated and how consistency with other MCO services and covered benefits is assessed.

27. Clinical practice guidelines for disease and chronic illness management recommended by the MCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated and how consistency with other MCO services and covered benefits is assessed.

28. A list of physicians currently available for utilization consultation/review and their specialty.

29. A copy of the provider handbook or manual.

30. A sample provider contract.

31. Documentation supporting requirements included in the Information Systems Capabilities Assessment for Managed Care Organizations (ISCAs). Please provide the following:
    a. A completed ISCA. *(Not a summarized ISCA or a document that contains ISCA-like information, but the ISCA itself.)*
    b. A network diagram showing (at a minimum) the relevant components in the information gathering, storage, and analysis processes. *(We are interested in the processing of claims and data in South Carolina, so if the health plan in South Carolina is part of a larger organization, the emphasis or focus should be on the network resources that are used in handling South Carolina data.)*
    c. A flow diagram or textual description of how data moves through the system. *(Please see the comment on b. above.)*
    d. A copy of the IT Disaster Recovery Plan or Business Continuity Plan.
    e. A copy of the most recent disaster recovery or business continuity plan test results.
    f. An organizational chart for the IT/IS department and a corporate organizational chart that shows the location of the IT organization within the corporation.
    g. A copy of the most recent data security audit, if completed.
    h. A copy of the policies or program description that address the information systems security and access management. Please also include polices with respect to email and PHI.
    i. A copy of the Information Security Plan & Security Risk Assessment.

32. A listing of all delegated activities, the name of the subcontractor(s), methods for oversight of the delegated activities by the MCO, and any reports of activities submitted by the subcontractor to the MCO.

33. Sample contract used for delegated entities. Specific written agreements with subcontractors may be requested at the onsite review at CCME's discretion.

34. Results of the most recent monitoring activities for all delegated activities. Include a full description of the procedure and/or methodology used and a copy of any tools used.
35. All HEDIS data and other performance and quality measures collected or planned. Required data and information include the following:
    a. data collection methodology used (e.g., administrative data, including sources; medical record review, including how records were identified and how the sample was chosen; hybrid methodology, including data sources and how the sample was chosen; or survey, including a copy of the tool, how the sample was chosen and how the data was input), including a full description of the procedures;
    b. reporting frequency and format;

c. specifications for all components used to identify the eligible population (e.g., member ID, age, sex, continuous enrollment calculation, clinical ICD-9/CPT-4 codes, member months/years calculation, other specified parameters);
d. programming specifications that include data sources such as files/databases and fields with definitions, programming logic and computer source codes;
e. denominator calculations methodology, including:
    1) data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
    2) specifications for all components used to identify the population for the denominator;
f. numerator calculations methodology, including:
    1) data sources used to calculate the numerator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
    2) specifications for all components used to identify the population for the numerator;
g. calculated and reported rates.

36. Provide electronic copies of the following files:
    a. Credentialing files (including signed Ownership Disclosure Forms) for:
        i. Ten PCP's (Include two NP's acting as PCP's, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two network hospitals; and
        v. One file for each additional type of facility in the network.
    b. Recredentialing (including signed Ownership Disclosure Forms) files for:
        i. Ten PCP's (Include two NP's acting as PCP's, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two network hospitals; and
        v. One file for each additional type of facility in the network.
    c. Twenty medical necessity denial files made in the months of October 2015 through November 2016. Include any medical information and physician review documentations used in making the denial determination. Please include two behavioral health files and two acute inpatient rehabilitation files.
    d. Twenty-five utilization approval files (acute care and behavioral health) made in the months of October 2015 through November 2016, including any medical information and approval criteria used in the decision. Please include prior authorizations for surgery and/or hospital admissions, concurrent stay, and retrospective review of admissions and of emergency care.

    Note: Appeals, Grievances, and Care Coordination/Case Management files will be selected from the logs received with the desk materials. A request will then be sent to the plan to send electronic copies of the files to CCME.

These materials:

- **should be organized and uploaded to the secure CCME EQR File Transfer site at https://eqro.thecarolinascenter.org**
- **and submitted in the categories listed.**

B. Attachment 2: Materials Requested for Onsite Review

External Quality Review 2016

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were copied.
2. A policy that defines the clinical criteria used for review of mental/behavioral health authorization requests.
3. The file for any member that was involuntarily disenrolled form ATC in the past 12 months.
4. A copy of policy/procedure CC.UM.02.05 addressing corrective action plans for inter-rater reliability testing.
5. A copy of the Member to Do List and a copy of materials provided to new members within 14 days of enrollment.
6. Organizational chart for the Credentialing Department.
7. Results of the provider After Hours Survey conducted in 2016.
8. Medical Record audit information conducted in 2016, if applicable.
9. Attachments A & B to policy SC.PRVR.13, Provider Orientations.
10. The following credentialing files were missing information or need explanation:
    a. Sharrel Odom, NP - Nurse Practitioner file included information regarding the supervising physician but did not include a copy of the written protocols.
    b. Julia Mullins, DO – Malpractice Insurance does not show the name of the covered physician; the NPPES search was not in the file.
    c. Irene Hallock, APRN- Malpractice Insurance does not show the name of the covered practitioner; page 16 of application regarding laboratory services is incomplete and there is no information in the file verifying if laboratory services are provided.
11. The following recredentialing files were missing information or need explanation:
    a. Harmon Patrick MD - Malpractice Insurance does not show the name of the covered physician; the NPPES search was not in the file; and the ownership disclosure form was dated 5/27/13 for recredentialing – how does ATC ensure there were no changes since 5/27/13?
    b. John Sonfield MD - The NPPES search was not in the file; and the checklist did not indicate the Quality Data information had been reviewed.
    c. Karen Staples, FNP - the NPPES search was not in the file; the checklist did not indicate the Quality Data information had been reviewed; and the ownership disclosure form was dated 2/21/13 for recredentialing - how does ATC ensure there were no changes since 2/21/13?
    d. Joe Castles, MD - The NPPES search was not in the file.
12. Please provide files or explanation as to why no credentialing and recredentialing files were received for organizational/facility providers that was requested in the desk materials request.

C. Attachment 3: EQR Validation Worksheets

- Performance Measure Validation
- Performance Improvement Project Validation
  - MEMBER SATISFACTION (NON-CLINICAL)
  - DIABETIC EYE EXAM
- Member Satisfaction Survey Validation – CAHPS Adult
- Member Satisfaction Survey Validation – CAHPS Child

CCME EQR PM VALIDATION WORKSHEET

Plan Name:	**ABSOLUTE TOTAL CARE**
Name of PM:	**HEDIS**
Reporting Year:	**MY 2015**
Review Performed:	**2016**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS Technical Specifications Vol. 5, 2016

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	
D2. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**MET**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	
N3. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**MET**	
N4. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**MET**	
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**MET**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling	Sample was unbiased.	**MET**	
S2. Sampling	Sample treated all measures independently.	**MET**	
S3. Sampling	Sample size and replacement methodologies met specifications.	**MET**	

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting	Was the measure reported accurately?	**MET**	
R2. Reporting	Was the measure reported according to State specifications?	**MET**	

VALIDATION SUMMARY			
Element	**Standard Weight**	**Validation Result**	**Score**
G1	10	MET	10
D1	10	MET	10
D2	5	MET	5
N1	10	MET	10
N2	5	MET	5
N3	5	MET	5
N4	5	MET	5
N5	5	MET	5
S1	5	MET	5
S2	5	MET	5
S3	5	MET	5
R1	10	MET	10
R2	5	MET	5

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**85**
Measure Weight Score	**85**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PIP Validation Worksheet

Plan Name:	**ABSOLUTE TOTAL CARE**
Name of PIP:	**MEMBER SATISFACTION (NON-CLINICAL)**
Reporting Year:	**2016**
Review Performed:	**2016**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	ATC member rating for rating of health plan was below the Book of Business average rate.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This PIP addresses enrollee care and services.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	All targeted populations were included.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	Research question is stated clearly on page 3 of PIP summary.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Indicator is clearly defined.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measures changes in enrollee satisfaction.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	Enrollees are defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	Data captures the relevant population sector.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**MET**	The study used the NCQA protocol for sampling.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**MET**	The study used the NCQA protocol for sampling.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**MET**	The study used the NCQA protocol for sampling.

Component / Standard (Total Points)	Score	Comments
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are documented.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Design is systematic in collecting valid and reliable data.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments for data collection are adequate and valid.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	The Data Analysis Plan is documented.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	A qualified vendor collected the data.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions to address barriers are documented.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analyses were performed according to the Data Analysis Plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	PIP results were presented clearly and accurately on page 20.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and re-measurement 1 are identified; documentation regarding factors for comparability and validity are noted.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Interpretation of the findings is provided.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**MET**	Methodology is the same at baseline and the follow-up measurement.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	The rate stayed the same from 72.6% to 72.7%, a very slight increase.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**N/A**	There was no improvement to validate face validity.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**N/A**	There was no improvement to validate statistical significance.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**N/A**	There was only one repeat measurement; this element cannot be evaluated at this time.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**MET**	Study findings were verified in CAHPS Adult report submitted by SPH Analytics.

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	5	5
5.2	10	10
5.3	5	5
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

Steps	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	10
Step 8		
8.1	5	5
8.2	10	10
8.3	1	1
8.4	1	1
Step 9		
9.1	5	5
9.2	1	1
9.3	NA	NA
9.4	NA	NA
Step 10		
10.1	NA	NA
Verify	20	20

Project Score	125
Project Possible Score	125
Validation Findings	100%

AUDIT DESIGNATION
HIGH CONFIDENCE

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR PIP Validation Worksheet

Plan Name:	**ABSOLUTE TOTAL CARE**
Name of PIP:	**DIABETIC EYE EXAM**
Reporting Year:	**2016**
Review Performed:	**2016**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	ATC's hybrid rate for this measure was below the NCQA quality compass 25th percentile.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This PIP addresses enrollee care and services.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	All targeted populations were included.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	Research question is stated clearly on page 4 of PIP summary.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	The indicator is a HEDIS measure.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	The indicator measures changes in processes of care.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	Enrollees are defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	Data captures the relevant population sector.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**MET**	The study used HEDIS guidelines for sampling; margin of error was reported.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**MET**	The study used HEDIS guidelines for sampling.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**MET**	The study used HEDIS guidelines for sampling.

Component / Standard (Total Points)	Score	Comments
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are documented.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Design is systematic in collecting valid and reliable data.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments for data collection are adequate.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is documented.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	The study documents that qualified staff collected the data.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions to address barriers are documented.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analyses were performed according to the data analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	PIP results were presented clearly and accurately on page 18.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and re-measurement 1 are identified; documentation regarding factors for comparability and validity are noted.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Interpretation of the findings is provided.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**MET**	Methodology is the same at baseline and the follow-up measurement.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	The rate improved from 40.8% to 51.39%.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	The improvement appears to be a result of the interventions.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	There is statistical evidence (p-value) that the improvement is true improvement.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**N/A**	There is only one repeat measurement; thus, this element cannot be evaluated at this time.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**MET**	The rate of 51.39% for retinal eye exam is documented in the HEDIS workbook.

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	5	5
5.2	10	10
5.3	5	5
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

Steps	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	10
Step 8		
8.1	5	5
8.2	10	10
8.3	1	1
8.4	1	1
Step 9		
9.1	5	5
9.2	1	1
9.3	5	5
9.4	1	1
Step 10		
10.1	NA	NA
Verify	20	20

Project Score	131
Project Possible Score	131
Validation Findings	100%

AUDIT DESIGNATION
HIGH CONFIDENCE

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR Survey Validation Worksheet

Plan Name	**ABSOLUTE TOTAL CARE**
Survey Validated	**CAHPS MEDICAID ADULT 5.0H**
Validation Period	2016
Review Performed	2017

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted, since the lack of information is relevant to the assessment of that activity. (V2 updated based on September 2012 version of EQR protocol 5)

ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND INTENDED USE

Survey Element		Element Met / Not Met	Comments And Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	The statement of purpose is documented. Documentation: *2016 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	The study objectives are clearly documented. Documentation: *2016 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Intended audience is identified and documented. Documentation: *2016 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*

ACTIVITY 2: ASSESS THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

Survey Element		Element Met / Not Met	Comments And Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**MET**	Reliability of the survey is documented. Documentation: *2016 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**MET**	Validity of the survey and responses are documented. Documentation: *2016 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments And Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Definition of the study population was clearly defined. Documentation: *2016 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Specifications for sample frame were clearly defined. Documentation: *2016 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	The sampling strategy was appropriate. Documentation: *2016 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**MET**	The required sample size is 1,350 according to NCQA. ATC had a sample size of 1,823. Documentation: *2016 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Appropriate procedures were used to select the sample. Documentation: *2016 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments And Documentation
4.1	Review the specifications for calculating raw and adjusted response rates to make sure they are clear and appropriate.	**MET**	Specifications for calculating raw and adjusted response rates were aligned with NCQA protocol, and are clear and appropriate. Documentation: *2016 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*
4.2	Assess the response rate, potential sources of nonresponse and bias, and implications of the response rate for the generalize ability of survey findings.	**NOT MET**	The overall response rate was 27.7% (n=494 valid surveys). The target response rate according to NCQA is 40.0%. The target number of valid surveys (n=411) was met, although the response rate was below the NCQA target rate. Documentation: *2016 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS* *Recommendation: Implement strategies to increase response rates and work with vendor to find ways to reach more respondents.*

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments And Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	A Quality Assurance Plan was in place. Documentation: *2016 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the planned approach. Documentation: *2016 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*
5.3	Were confidentiality procedures followed?	**MET**	Confidentiality procedures were followed. Documentation: *2016 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS

Survey Element		Element Met / Not Met	Comments And Documentation
6.1	Was the survey data analyzed?	**MET**	Data were analyzed. Documentation: *2016 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate statistical tests were conducted. Documentation: *2016 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Survey conclusions were supported by findings. Documentation: *2016 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

Results Elements		Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	•The use of a CAHPS certified vendor allows for a standardized and audited approach to the implementation and analysis of the surveys. •SPH Analytics as a vendor provides a full report of process and results that meets the necessary requirements and expectations of a survey report.
7.2	Identify the technical weaknesses of the survey and its documentation.	No technical weaknesses were noted in the review.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	The overall response rate was 27.7%. The target response rate according to NCQA is 40.0%, thus, caution should be utilized when generalizing the results to the population.
7.4	What conclusions are drawn from the survey data?	Regarding composite scores: The Getting Needed Care composite was at 78.0% which was lower than the two previous years' rates. The Getting Care Quickly rate was at 81.3% which was lower than the 2015 rate but higher than the 2014 rate. The How Well Doctors communicate rate was at 93.2% which is higher than both of the previous years' rates. The Customer Service 2016 rate was 84.1%, which was lower than the two previous years' rates. The Shared Decision Making rate was 75.9% this year, which was lower than the 2015 rate of 77.6%. Documentation: 2016 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	CAHPS Results from the previous year were provided to members in a brief summary on the Provider site. Documentation: https://www.absolutetotalcare.com/content/dam/centene/absolute-total-care/pdfs/P16-003%20-%20Quality%20Improvement%20Program%20Description_update08102016.pdf
7.6	Comparative information about all MCOs (as appropriate).	Comparative information was provided and documented. Documentation: *2016 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*

CCME EQR Survey Validation Worksheet

Plan Name	**ABSOLUTE TOTAL CARE**
Survey Validated	**CAHPS CHILD 5.0H**
Validation Period	2016
Review Performed	2017

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted, since the lack of information is relevant to the assessment of that activity. (V2 updated based on September 2012 version of EQR protocol 5)

ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND INTENDED USE

Survey Element		Element Met / Not Met	Comments And Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	The statement of purpose is documented. Documentation: *2016 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	The study objectives are clearly documented. Documentation: *2016 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Intended audience is identified and documented. Documentation: *2016 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*

ACTIVITY 2: ASSESS THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

Survey Element		Element Met / Not Met	Comments And Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**MET**	Reliability of the survey is documented. Documentation: *2016 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**MET**	Validity of the survey and responses are documented. Documentation: *2016 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments And Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Definition of the study population was clearly defined. Documentation: *2016 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Specifications for sample frame were clearly defined. Documentation: *2016 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	The sampling strategy was appropriate. Documentation: *2016 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**MET**	The required sample size is 1,650 according to NCQA. ATC had a sample size of 2,558. Documentation: *2016 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Appropriate procedures were used to select the sample. Documentation: *2016 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments And Documentation
4.1	Review the specifications for calculating raw and adjusted response rates to make sure they are clear and appropriate.	**MET**	Specifications for calculating raw and adjusted response rates were aligned with NCQA protocol, and are clear and appropriate. Documentation: *2016 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*
4.2	Assess the response rate, potential sources of nonresponse and bias, and implications of the response rate for the generalize ability of survey findings.	**NOT MET**	The overall response rate was 24.5% (n=611 valid surveys). The target response rate according to NCQA is 40.0%. The target number of valid surveys (n=411) was met, although the response rate was below the NCQA target rate. Documentation: *2016 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS* *Recommendation: Implement strategies to increase response rates and work with vendor to find ways to reach more respondents.*

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments And Documentation
5.1	Was a quality assurance plan(s) in place that covers the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	A Quality Assurance Plan was in place. Documentation: *2016 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the planned approach. Documentation: *2016 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*
5.3	Were confidentiality procedures followed?	**MET**	Confidentiality procedures were followed. Documentation: *2016 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS

Survey Element		Element Met / Not Met	Comments And Documentation
6.1	Was the survey data analyzed?	**MET**	Data were analyzed. Documentation: *2016 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate statistical tests were conducted. Documentation: *2016 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Survey conclusions were supported by findings. Documentation: *2016 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

Results Elements		Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	•The use of a CAHPS certified vendor allows for a standardized and audited approach to the implementation and analysis of the surveys. •As a vendor, SPH Analytics provides a full report of process and results that meets the necessary requirements and expectations of a survey report.
7.2	Identify the technical weaknesses of the survey and its documentation.	No technical weaknesses were noted in the review.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	The overall response rate was 24.5%. The target response rate according to NCQA is 40.0%, hence, use caution when generalizing the results to the population.
7.4	What conclusions are drawn from the survey data?	The plan scored at 32nd percentile on rating of Health Plan; for Getting needed Care the percentile rank was 83rd, which was significantly higher compared to the benchmark; Customer Service was at the 51st percentile; and Ease of Filling out Forms was at the 65th percentile. Documentation: *2016 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	CAHPS results were provided to members in a brief summary in the winter/spring provider newsletter and on the provider site. Documentation: P16-038 Winter-Spring Newsletter https://www.absolutetotalcare.com/content/dam/centene/absolute-total-care/pdfs/P16-003%20-%20Quality%20Improvement%20Program%20Description_update08102016.pdf
7.6	Comparative information about all MCOs (as appropriate).	Comparative information was provided and documented. Documentation: *2016 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*

D. Attachment 4: Tabular Spreadsheet

The Carolinas Center *for* Medical Excellence

CCME MCO Data Collection Tool

Plan Name:	**Absolute Total Care**
Collection Date:	2016

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I. ADMINISTRATION						
I A. General Approach to Policies and Procedures						
1. The MCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					Absolute Total Care (ATC) has a comprehensive and well organized set of policies, procedures, and work processes. ATC utilizes Compliance 360 to track policy changes and annual review schedules. Evidence of annual review and updating was documented on each policy. All employees can access policies and procedures via a shared intranet.
I B. Organizational Chart / Staffing						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO's resources are sufficient to ensure that all health care products and services required by the State of South Carolina are provided to members. At a minimum, this includes designated staff performing in the following roles:						The submitted organization chart indicates sufficient staff to enable ATC to perform the tasks necessary to ensure the provision of health care and services to their members.
1.1 *Administrator (CEO, COO, Executive Director);	X					Plan President and CEO Paul Accardi is accountable for day-to-day business activities. He is accountable to the Board of Directors and ATC's parent organization, Centene Corporation, located in St. Louis, Missouri. Wendy Bailey serves as vice president of operations. ATC achieved a "Commendable" rating from the National Committee of Quality Assurance (NCQA).
1.2 Chief Financial Officer;	X					Stephen Moore is the vice president of finance.
1.3 * Contract Account Manager;	X					Jennifer Marchant is the manager of compliance and is also the contract account manager.
1.4 Information Systems personnel;						Centene's Corporate Information Technology (IT) department supports ATC. Sydney Stone is ATC's senior director of provider and data analytics in South Carolina.
1.4.1 Claims and Encounter Manager/Administrator,	X					Cynthia Jones is the senior director of claims. She is supported by claims liaisons and overseen by the director of operations.
1.4.2 Network Management Claims/Encounter Processing Staff,	X					The vice president of finance and his team manage data encounter submissions to SCDHHS.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5 Utilization Management (Coordinator, Manager, Director);	X					Madonna Lumsden is the vice president of medical management. She oversees the directors of utilization management (UM), case management (CM), and appeals and grievances. According to the *UM Program Description*, the vice president of medical management, in collaboration with the medical director, assists with the development of the UM strategic vision in alignment with Centene Corporation and plan objectives, policies, and procedures.
1.5.1 Pharmacy Director,	X					Jenna Meisner is the senior director of pharmacy and a registered pharmacist in South Carolina.
1.5.2 Behavioral Health Coordinator,	X					Cenpatico is a partner within Centene that administers Behavioral Health Services for ATC. Michelle Thomas is the senior director of clinical operations for Cenpatico. Behavioral health and physical health utilization staff work together to promote appropriate and timely provision of integrated services.
1.5.3 Utilization Review Staff,	X					The submitted organization chart demonstrates ATC has ample staff performing utilization functions in a timely manner.
1.5.4 *Case Management Staff,	X					
1.6 *Quality Improvement (Coordinator, Manager, Director);	X					Joyce McElwain is vice president of quality improvement and is supported by managers, Health Effectiveness Data and Information Set (HEDIS®) coordinators, and clinical nurse liaisons. Nurse liaisons contribute to data abstraction and educate providers about complete documentation and billing practices

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						related to quality measures.
1.6.1 Quality Assessment and Performance Improvement Staff,	X					
1.7 *Provider Services Manager;	X					Donald Pifer is the vice president of network development and contracting. SaBrina Macon serves as the director of the provider network.
1.7.1 *Provider Services Staff,	X					Provider network specialists ensure providers receive mandatory training upon joining ATC and ongoing training during face-to-face provider office visits. In addition to the *Provider Manual*, providers have access to webinars and the provider portal on the ATC website.
1.8 *Member Services Manager;	X					Del Allen is ATC's senior director of customer services.
1.8.1 Member Services Staff,	X					
1.9 *Medical Director;	X					Dr. Robert Thompson is ATC's medical director. According to the *UM Program Description*, the medical director oversees every aspect of the UM program. Dr. Thompson is currently licensed to practice medicine in South Carolina as a doctor of osteopathic medicine (DO) specializing in family practice. The medical director is required to supervise all medical necessity decisions and conduct Level II medical necessity reviews. There are 3 part-time medical director consultants with specialties in internal medicine and geriatrics. The additional full-time medical director position was recently filled.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.10 *Compliance Officer;	X					Talvin Herbert is ATC's vice president of compliance and serves as the privacy officer.
1.11 * Interagency Liaison;	X					Manager of Compliance Jennifer Marchant, with the support of compliance staff, medical management staff, and case management staff, ensures coordination of services across provider types.
1.12 Legal Staff.	X					
2. Operational relationships of MCO staff are clearly delineated.	X					
3. Operational responsibilities and appropriate minimum education and training requirements are identified for all MCO staff positions.	X					ATC and Centene Corporate staff are aware of the SCDHHS contract requirement for post-payment review staff and the required qualifications. Numerous post-payment review processes are used to identify irregularities. Centene sends qualified post-payment review staff to SC to conduct onsite post payment reviews as needed.
I C. Management Information Systems						
1. The MCO processes provider claims in an accurate and timely fashion.	X					ATC's Information System Capabilities Assessment (ISCA) documentation indicates claims are monitored for timeliness and accuracy. The plan meets the organization's internal requirements and surpasses the MCO contract requirements by completing more than 99% of clean claims in 30 days and 100% of clean claims within 90 days.
2. The MCO is capable of accepting and generating	X					ATC's electronic and paper claims data is checked for Health Insurance Portability and Accountability Act (HIPAA) compliance through

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
HIPAA compliant electronic transactions.						an integrated EDIFECS system and then processed through HIPAA translation software. If clean, the claim data are loaded for electronic adjudication in ATC's AMISYS system. The AMISYS system electronically manages member eligibility, provider eligibility, prior authorization, and pricing.
3. The MCO tracks enrollment and demographic data and links it to the provider base.	X					ATC uses the Medicaid ID on 834 files as a basis to generate a unique ID to identify enrollees. To prevent ID duplication, ATC employs logic that finds duplicate social security numbers. If a duplicate number is found, the member record errors out for a manual review.
4. The MCO management information system is sufficient to support data reporting to the State and internally for MCO quality improvement and utilization monitoring activities.	X					Claims and member data are loaded from ATC's enterprise data warehouse into the Catalyst Quality Spectrum Insight (QSI) application to generate HEDIS reports. Additionally, ATC's claims processing is monitored daily and monthly to ensure they meet internal benchmarks and accuracy standards.
5. The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract.	X					ATC's parent organization, Centene, has a third party audit performed annually. That audit reports the capabilities and effectiveness of the controls used to manage ATC's claims processing systems. The audit report also addresses application access controls, network security controls, and physical security controls.
6. The MCO has policies, procedures and/or processes in place for addressing system and information security and access management.	X					ATC/Centene's ISCA documentation indicates adequate policies and procedures are in place to secure data as required by the MCO contract. Additionally the documentation provided summarizes the security measures in place to protect and control the data within claims

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						processing systems.
7. The MCO has a disaster recovery and/or business continuity plan, such plan has been tested, and the testing has been documented.	X					ATC/Centene has a well-documented *Disaster Recovery Plan* which was last tested in May 2016. The *Disaster Recovery Test Report* indicates that ATC/Centene was able to satisfy the requirements needed to restart operations should a disaster occur.
I D. Compliance/Program Integrity						
1. The MCO has policies, procedures, and a Compliance Plan that are consistent with state and federal requirements to guard against fraud and abuse.	X					The following documents include the federal requirements and the *SCDHHS Contract* requirements for a Compliance Plan and measures to detect and prevent fraud, waste, and abuse: •*SC.COMP.01, Compliance and Ethics Program Description* •*Policy CC.COMP.16, Fraud, Waste, and Abuse Plan* •*Policy CC.COMP.11, Compliance with State Contracts* •*Policy CC.COMP.05, Prohibiting Retaliation Against Employees, Individuals, or Others, and* •*Policy CC.COMP.03, Speaking Up-Reporting Concerns or Policy Violations, Misconduct.* The vice president of compliance reports to the CEO and the Board of Directors. The compliance officer is accountable to ATC's senior management and is responsible for ensuring that policies to establish compliance guidelines, including effective lines of communication, are developed and followed.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The MCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.	X					The Compliance Committee is an ATC Board of Directors committee. The compliance officer chairs ATC's Compliance Committee, which meets on a quarterly and ad hoc basis. Compliance Committee members include, but are not limited to, the plan president & CEO, vice president of compliance and regulatory affairs, vice president of finance, vice president of medical management, and the vice president of operations. A quorum is met with 3 voting members in attendance. The committee minutes reflect good attendance and document a quorum was met for all meetings. Anonymous compliance hotline numbers are well-publicized in the *Member Handbook*, *Provider Manual*, website, health plan offices, and the *Employee Handbook*. Annual training is required.
I E. Confidentiality						
1. The MCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					ATC has numerous policies on confidentiality and Protected Health Information (PHI). Policies address HIPAA and the release or disclosure of PHI using applicable law and appropriate consents. Members receive the Notice of Privacy Practices in the *Member Handbook* and are informed annually in member newsletters of their right to request a copy by calling Member

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Services. The Compliance Committee minutes and onsite discussion confirmed an issue of inadequate locked storage for PHI occurred during the process of moving staff to a different floor in their current offices. ATC resolved this issue by providing a large, locked area for storage and improving the functionality of individual desk locks.

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II. PROVIDER SERVICES						
II A. Credentialing and Recredentialing						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in manner consistent with contractual requirements.	X					ATC's credentialing program for practitioners is addressed in *Policy CC.CRED.01, Practitioner Credentialing & Recredentialing*, which defines the procedures for network selection and retention. Organizational provider credentialing is addressed in *Policy CC.CRED.09, Organizational Assessment and Reassessment*. The policies are detailed and specific state requirements are addressed via footnotes and attachments.
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the MCO.	X					The Credentialing Committee is chaired by Medical Director Dr. Shalini Mittal. Additional voting members include Medical Director Dr. Robert Thompson and three network providers with the specialties of pediatrics and surgery. *Policy CC.CRED.03, Credentialing Committee*, defines the composition, responsibilities, and meeting protocols. The committee meets monthly and reports to the QIC quarterly. A review of Credentialing Committee minutes showed good voting member participation. A quorum is met with 2/3 of the voting members in attendance and meeting minutes reflect that a quorum is established at each meeting. Onsite discussion revealed that a network physician with a specialty of surgery is currently being added to the Credentialing Committee.
3. The credentialing process includes all elements required by the contract and by the MCO's internal policies.	X					The credentialing file review showed the files were organized and, for the most part, contained appropriate documentation. One nurse practitioner

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						file did not contain proof of written protocols. *Recommendation: Ensure written protocols are collected for all nurse practitioners being credentialed.*
3.1 Verification of information on the applicant, including:						
3.1.1 Current valid license to practice in each state where the practitioner will treat members;	X					
3.1.2 Valid DEA certificate and/or CDS Certificate;	X					
3.1.3 Professional education and training, or board certification if claimed by the applicant;	X					
3.1.4 Work history;	X					
3.1.5 Malpractice claims history;	X					
3.1.6 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application;	X					
3.1.7 Query of the National Practitioner Data Bank (NPDB);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.8 No debarred, suspended, or excluded from Federal procurement activities: Query of System for Award Management (SAM);	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline); State Excluded Provider's Report;	X					
3.1.10 Query for Medicare and/or Medicaid sanctions (5 years); OIG List of Excluded Individuals and Entities (LEIE);	X					
3.1.11 In good standing at the hospitals designated by the provider as the primary admitting facility. (hospital privileges/coverage plan);	X					
3.1.12 Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures;	X					
3.1.13 Ownership Disclosure form .	X					
3.2 Site assessment, including but not limited to adequacy of the waiting room and bathroom, handicapped accessibility, treatment room privacy, infection control practices, appointment availability, office waiting time, record keeping methods, and confidentiality measures.	X					*Policy CC.CRED.05, Practitioner Office Site Review*, defines the criteria for provider office site reviews. Standards are determined based on National Committee for Quality Assurance (NCQA) guidelines and/or State regulations. For sites that do not meet an overall minimum score of 80%, follow-up action plans are developed and revisits are scheduled at

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						least every six months until performance standards are met. ATC delegates credentialing and site visits for behavioral health practitioners to Cenpatico Behavioral Health and monitors their performance of this activity in accordance with the *Oversight of Delegated Credentialing Policy CC.CRED.12*. Onsite discussion confirmed that ATC is not currently conducting provider office site reviews at initial credentialing in accordance with updates made to the *SCDHHS Policy & Procedure Guide*, and ATC follows *NCQA* guidelines.
3.3 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the MCO's internal policies.	X					The recredentialing file review showed the files were organized and, for the most part, contained appropriate documentation. One file did not contain proof of search for the NPPES. *Recommendation: Ensure proof of query for the NPPES is in the credentialing/recredentialing files.*
4.1 Recredentialing every three years;	X					
4.2 Verification of information on the applicant, including:						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.1 Current valid license to practice in each state where the practitioner will treat members;	X					
4.2.2 Valid DEA certificate;	X					
4.2.3 Board certification if claimed by the applicant;	X					
4.2.4 Malpractice claims since the previous credentialing event;	X					
4.2.5 Practitioner attestation statement;	X					
4.2.6 Requery the National Practitioner Data Bank (NPDB);	X					
4.2.7 Requery of Service System for Award Management (SAM);	X					
4.2.8 Requery for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline); State Excluded Provider's Report;	X					
4.2.9 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event; OIG List of Excluded Individuals and Entities (LEIE);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.10 In good standing at the hospitals designated by the provider as the primary admitting facility. (hospital privileges/coverage plan);	X					
4.2.11 Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures;	X					
4.2.12 Ownership Disclosure form.	X					
4.3 Site reassessment if the provider location has changed since the previous credentialing activity.		X				*Policy CC.CRED.05, Practitioner Office Site Review,* states the Quality Improvement Department monitors for deficiencies related to a practitioner's office by monitoring member complaints and grievances and/or member survey information. The policy states that upon identification of complaints related to quality of practitioner's office site, the Quality Improvement Department refers the office to Provider Relations to perform onsite visit within 30 days of identification that the complaint threshold has been met. The Plan has up to 60 calendar days to complete the site visit if necessary. However, *Attachment J* of the policy states that ATC must complete site visits within 45 calendar days of the complaint threshold being met regarding the quality of the provider's office. Onsite discussion confirmed this information needs to be updated to reflect the 60-day timeframe. *Quality Improvement Plan: Update Attachment J*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						of Policy CC.CRED.05, Practitioner Office Site Review, to reflect the 60-day timeframe being used by ATC for site visits as a result of a complaint threshold being met regarding the provider's office.
4.4 Review of practitioner profiling activities.	X					ATC provides performance feedback to providers through the Annual Physician Report Card, which is based on specific HEDIS measures and compares the ATC patient population for the practice to ATC's overall health plan score. CCME reviewed examples of provider profiling reports included in the desk materials. *Policy CC.CRED.01, Practitioner Credentialing & Recredentialing* states the recredentialing process takes into account provider-specific performance data such as those collected through the quality improvement program, the utilization management system, the grievance/complaint system, satisfaction surveys, and other activities of the organization. The credentialing designee gathers applicable performance data from the *QI department* designee for inclusion in the recredentialing file.
5. The MCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the MCO for serious quality of care or service issues.	X					*Policy SC.QI.08, Clinical Quality of Care Investigation,* defines the process of investigation, and review by the medical director with severity assignment and corrective action. It states that a Peer Review Committee and or Credentialing Committee may impose any corrective action deemed to be in the best interest of patient care and/or safety. ATC will notify the appropriate

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						authorities in accordance with all relevant state and federal peer review laws and regulations in the event a practitioner's network participation is suspended or terminated for reasons relating to the practitioner's competence or professional conduct. Additional policies such as *SC.CRED.07, Practitioner Disciplinary Action and Reporting*, and *SC.CRED.08, Practitioner Appeal Hearing Process*, define the process for disciplinary action and appeal.
6. Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities.		X				The credentialing and recredentialing requirements for healthcare delivery organizations are detailed in *Policy SC.CRED.05, Organizational Assessment and Reassessment*. The organizational provider credentialing/ recredentialing file review showed that 3 credentialing files did not have proof of query for the *SC Excluded Providers List*. *Quality Improvement Plan: Ensure proof of query of the SC Excluded Providers List is in the credentialing and recredentialing files.*
7. Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds.	X					*Policy CC.CRED.06, Ongoing Monitoring of Sanctions & Complaints*, states that ongoing monitoring is performed by credentialing on a monthly basis. Review is performed on all practitioners/providers listed in the provider data management system, regardless of participation status. Monitoring includes Medicare/Medicaid-specific exclusions or NPDB reports, Office of Inspector General (OIG), System for Award Management (SAM), and *SC Excluded Providers List*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The QI department monitors complaints received against practitioners.
II B. Adequacy of the Provider Network						
1. The MCO maintains a network of providers that is sufficient to meet the health care needs of members and is consistent with contract requirements.						
1.1 Members have a primary care physician located within a 30-mile radius of their residence.		X				*Policy SC.QI.04, Quality Improvement Evaluation of Practitioner's Availability,* defines the standards for assessing the availability of providers within the network. ATC measures PCPs with a minimum of one full time PCP within 30 miles and at least one practitioner per 2,500 members. Table 1 in the policy incorrectly states that standards by PCP type include at least <u>two</u> FPs or GPs within 30 miles. Onsite discussion confirmed it should reflect the standard of <u>one</u> FP or GP within 30 miles. These standards are measured for 95% of members to meet the standards. CCME reviewed GEO Access reports included in the desk materials. *Quality Improvement Plan: Correct Table 1 in Policy SC.QI.04, Quality Improvement Evaluation of Practitioner's Availability, to reflect the access standard of at least <u>one</u> FP or GP within 30 miles.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.2 Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty.	X					*Policy SC.QI.04, Quality Improvement Evaluation of Practitioner's Availability,* defines the accessibility measurement of specialists as one practitioner within 50 miles; evidence of compliant GEO Access reports was contained in the desk materials.
1.3 The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually.	X					*Policy SC.CONT.02, Network Adequacy,* states that ATC analyzes its network adequacy on a bi-annual basis by running Geo Access maps for all contracted PCPs, specialists, key ancillary services, and hospitals. ATC submits analysis reports to the SCDHHS on a bi-annual basis as prescribed by the *SCDHHS Contract*.
1.4 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.	X					*Policy SC.QI.26, Cultural Competency Plan,* states that ATC has a comprehensive written *Cultural Competency Plan (CCP)* describing the program to ensure that services are provided in a culturally competent manner to all members, including those with limited English proficiency. The CCP will be updated on an annual basis. *Policy SC.QI.04, Quality Improvement Evaluation of Practitioners Availability,* states that at least annually, ATC assesses the cultural, ethnic, racial and linguistic needs of its members and works to adjust the availability of practitioners within its network, if necessary. The 2016 *Cultural Competency Medicaid Plan* is listed on the ATC website and cultural competency information is included in the *Provider Manual*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5 The MCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					
2. The MCO maintains a provider directory that includes all requirements outlined in the contract.	X					ATC maintains a searchable *Provider Directory* on the website and members can request printed copies as well. The *Provider Directory* is updated via a daily feed that migrates provider data elements from ATC's Portico data management system which is used to maintain all network providers' demographic, credentialing and financial data elements.
3. Practitioner Accessibility						
3.1 The MCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	X					*Policy SC.QI.05, Evaluation of the Accessibility of Services*, defines appointment access standards that comply with contract guidelines. Appointment access standards are also listed in the *Provider Manual* and *Member Handbook*. At least annually, the QI department analyzes appointment accessibility including routine, urgent, and after-hours care against the standards it has defined. ATC conducted an appointment availability study in 2016 and results will be reported in the 2016 *QI Program Evaluation*. Overall results appear to show an average pass rate of 43%. Barriers were identified with opportunities for improvement such as educating non-compliant offices on the appointment access standards and improving the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						accuracy of information in the *Provider Directory*. ATC implemented a new process where provider demographic updates can easily be made locally and they feel this should help improve the accuracy of the provider demographic data. Results of the 2016 After Hours Survey showed a pass rate of 86%. Non-compliant providers will receive education and a resurvey within 90 days.
3.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results.			X			In reference to the results of the Telephone Provider Access Study conducted by CCME, calls were successfully answered 43% of the time by personnel at the correct practice which estimates to between 40 and 45% for the entire population. When compared to last year's results of 52%, this year's study proportion decreased from the previous measure. The results represent a statistically significant decrease. *Quality Improvement Plan: Regarding members' access to their providers, look for barriers in the update process for provider contact information and conduct data checks for accuracy of provider contact information.*
II C. Provider Education						
1. The MCO formulates and acts within policies and procedures related to initial education of providers.	X					*Policy SC.PRVR.13, Provider Orientations,* states that new provider orientations will be conducted within 30 business days of becoming active with ATC. Orientation is conducted for all newly contracted PCPs, specialists, hospitals and/or

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						ancillary providers who are not part of an existing in-network group or facility. Network Relations staff coordinate education/training to providers and all of their staff; and attendance is tracked. Providers also sign an attestation verifying that all staff who did not attend the orientation session will be provided the orientation information.
2. Initial provider education includes:						The *Provider Manual* is detailed, and is a good resource for understanding ATC's processes.
2.1 MCO health care program goals;	X					
2.2 Billing and reimbursement practices;	X					
2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS;	X					
2.4 Procedure for referral to a specialist;	X					
2.5 Accessibility standards, including 24/7 access;	X					
2.6 Recommended standards of care;	X					
2.7 Medical record handling, availability, retention and confidentiality;	X					
2.8 Provider and member grievance and appeal procedures;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.9 Pharmacy policies and procedures necessary for making informed prescription choices;	X					
2.10 Reassignment of a member to another PCP;	X					
2.11 Medical record documentation requirements.	X					
3. The MCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies and procedures.	X					*Policy SC.PRVR.13, Provider Orientations,* states that annual provider orientations may be conducted based on provider community RSVP or request from SCDHHS for training purposes to capture a broad audience of providers of all specialties. These multiple group orientations/training programs/seminars are advanced level workshops or webinars that will be held in a strategic location(s) throughout the state to offer ongoing education and health plan updates. Providers also receive education through regularly scheduled meetings with network relations specialists, information posted to the website's provider section, provider newsletters and bulletins, and provider fax blasts.
II D. Primary and Secondary Preventive Health Guidelines						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO develops preventive health guidelines for the care of its members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					ATC adopts and distributes preventive health guidelines to help practitioners and members make decisions about appropriate health care for specific clinical circumstances. The guidelines are presented to the QIC for review, approval, and adoption. The guidelines are updated upon significant new scientific evidence or changes in national standards and are reviewed at least every two years per *Policy SC.QI.08, Clinical & Preventive Practice Guidelines.*
2. The MCO communicates the preventive health guidelines and the expectation that they will be followed for MCO members to providers.	X					Preventive guidelines are addressed in the *Provider Manual* and posted to ATC's website. *Policy SC.QI.08, Clinical & Preventive Practice Guidelines*, states that additional mechanisms to notify and distribute guidelines may include, but are not limited to new practitioner orientation materials; provider and member newsletters; *Member Handbook;* special mailings; or fax blast.
3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Well child care at specified intervals, including EPSDTs at State-mandated intervals;	X					
3.2 Recommended childhood immunizations;	X					
3.3 Pregnancy care;	X					
3.4 Adult screening recommendations at specified intervals;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.5 Elderly screening recommendations at specified intervals;	X					
3.6 Recommendations specific to member high-risk groups.	X					
4. The MCO assesses practitioner compliance with preventive health guidelines through direct medical record audit and/or review of utilization data.	X					Preventive guideline compliance is measured retrospectively using HEDIS results on an annual basis. Care gap reports are available on a monthly basis for PCPs.
II E. Clinical Practice Guidelines for Disease and Chronic Illness Management						
1. The MCO develops clinical practice guidelines for disease and chronic illness management of its members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists.	X					*Policy SC.QI.08, Clinical & Preventive Practice Guidelines,* establishes the process by which ATC adopts, develops and distributes clinical and preventive practice guidelines to help practitioners and members make decisions about appropriate health care for specific clinical circumstances. Practice guidelines are derived from recognized sources and presented to the QIC for appropriate physician review and adoption. The guidelines are adopted for the provision of acute, chronic, and behavioral health services relevant to the population. Cenpatico Behavioral Health is the ATC-delegated managed behavioral health organization that performs the adoption, updating and distribution for the behavioral health guidelines.
2. The MCO communicates the clinical practice guidelines for disease and chronic illness management and the expectation that they will be followed for MCO members to providers.	X					Practitioner adherence to the adopted preventive and clinical practice guidelines is encouraged in the following ways: new provider orientations include the practice guidelines section of the *Provider*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Manual with discussion of ATC expectations; measures of compliance are shared in provider newsletter articles; and practice guidelines are posted to the ATC website.
3. The MCO assesses practitioner compliance with clinical practice guidelines for disease and chronic illness management through direct medical record audit and/or review of utilization data.	X					*Policy SC.QI.08, Clinical & Preventive Practice Guidelines,* states that at least annually, ATC measures practitioner compliance with at least two measures for each of the four clinical guidelines. The analysis can be either population or practice based. •For population based measurement, compliance to guidelines is assessed for members with specific acute or chronic conditions using HEDIS measures, when applicable. •For practice based measurement, a sample of the practitioner's records is evaluated for adherence to specific guidelines.
II F. Continuity of Care						
1. The MCO monitors continuity and coordination of care between the PCPs and other providers.	X					*Policy SC.QI.09, Continuity & Coordination Member Care,* defines the procedure for detecting problems in coordination and continuity of care between PCPs and other providers. This may include reviewing complaints/grievances, conducting PCP office record reviews to assess the adequacy of information, assessing the effectiveness of discharge planning, and assessing the quality of information exchanged between providers. The 2015 *Medicaid QI Program Evaluation* reflected that ATC monitored the following areas: inpatient post

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						discharge follow-up visit; post emergency department (ED) visit follow-up, postpartum follow-up; and practitioner satisfaction with the communication between PCPs and specialists. ATC identified barriers, made appropriate interventions, and tracked goals.
II G. Practitioner Medical Records						
1. The MCO formulates policies and procedures outlining standards for acceptable documentation in the member medical records maintained by primary care physicians.	X					*Policy SC.QI.13, Medical Record Review,* outlines the process by which ATC monitors its practitioners to ensure that medical records are maintained in a detailed and organized manner, and preserve patient confidentiality. At a minimum, medical record documentation reviews will be conducted every year for selected PCPs and specialists (OB/GYN). Additionally, ATC may conduct medical record reviews for the purposes including but not limited to utilization review, quality management, disease specific HEDIS measures, medical claim review, and member complaint/appeal investigation. Practitioners sampled must meet 80% of the requirements for medical record keeping or be subject to corrective action. Medical record review results are trended by the QI department to determine plan-wide areas in need of improvement. Minimum standards for medical record documentation are defined in the *Provider Manual*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Standards for acceptable documentation in member medical records are consistent with contract requirements.	X					
3. Medical Record Audit						
3.1 The MCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers.	X					ATC monitors selected practitioners annually for maintenance of medical records in a detailed, legible, and organized manner, which permits confidential and effective documentation of patient care. Standards for medical record keeping practices include medical record content, medical record organization, ease of retrieving medical records, and maintaining confidentiality of patient information. The 2016 medical record review included a review of 70 practitioners and 350 medical records. All practitioners received a total pass score of 80% or greater. The overall score for audit year 2016 was 95%, which was four percentage points lower than the 2015 review. Since the ATC goal of 80% or greater was met, no practitioners were placed on a corrective action plan.
4. Accessibility to member medical records by the MCO for the purposes of quality improvement, utilization management, and/or other studies is contractually assured for a period of 5 years following expiration of the contract.	X					

III. MEMBER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III. MEMBER SERVICES						
III A. Member Rights and Responsibilities						
1. The MCO formulates and implements policies outlining member rights and responsibilities and procedures for informing members of these rights and responsibilities.	X					*Policy SC.MBRS.25, Member Rights and Responsibilities,* states ATC members receive a member packet and *Member Handbook* upon enrollment. Member rights are included in the handbook. Members are informed of their rights and responsibilities at least yearly via a member newsletter or direct mailing. Providers are expected to respect and honor member rights.
2. Member rights include, but are not limited to, the right:	X					All of the required member rights and responsibilities are found in the *Provider Manual*, the *Member Handbook*, the ATC website, and *Policy SC.MBRS.25, Member Rights and Responsibilities.* One of the member responsibilities listed is not found in the *Federal Regulations* or *SCDHHS Contract*. During onsite discussion, it was revealed that the statement "To choose a person to act on their behalf" is referring to a member allowing someone to speak for them during a phone conversation with ATC. With verbal consent, ATC will provide minimal information, but further conversations require evidence of a Power of Attorney (POA) document. ATC tracks the receipt of the POA from members. The intent of this responsibility is not clearly explained in the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						following documents: •*Policy SC.MBRS.25, Member Rights and Responsibilities,* states "To choose a person to represent them for the use of their information by ATC if they are unable to." •*The Provider Manual* states the ATC member has the responsibility "To choose a person to act on their behalf." •The *Member Handbook* states "To choose a person to act on their behalf." •The ATC website states "To choose a person to represent them for the use of their information by Absolute Total Care if they are unable to." *Recommendation: Update the language in the documents noted to clearly explain the intent of this responsibility. Consider moving this to the list of rights instead of responsibilities because members can do so if they choose but do not have a responsibility to do this.*
2.1 To be treated with respect and dignity;						
2.2 Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						
2.3 To participate in decision-making regarding their health care, including the right to refuse treatment;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.4 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with Federal regulations;						
2.5 To be able to request and receive a copy of the member's medical records and request that they be amended or corrected as specified in Federal regulation;						
2.6 To freely exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO and it providers or the Department treat the Medicaid MCO Member.						
III B. Member MCO Program Education						
1. Members are informed in writing within 14 business days of enrollment of all benefits to which they are contractually entitled, including:	X					*Policy SC.ELIG.17, Enrollment*, states welcome packets with ID cards are generated through the vendor Cenveo. This process outlines that members should receive the packets within 14 days. The *Member Handbook* includes all the contract requirements listed in this section.
1.1 Full disclosure of benefits and services included and excluded in their coverage;						
1.1.1 Benefits include direct access for female members to a women's health specialist in addition to a PCP;						
1.1.2 Benefits include access to 2nd opinions at no cost including use of an out-of-network provider if necessary.						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.2 How members may obtain benefits, including family planning services from out-of-network providers;						
1.3 Any applicable deductibles, copayments, limits of coverage, maximum allowable benefits and claim submission procedures;						*The Member Handbook*, page 16, states there is a copayment of $3.40 for Behavioral Health & Alcohol, Drug and Substance abuse (outpatient); however, this copayment is not found on the website. *Recommendation: Update the copay information on the website to include the copayment for services noted above.*
1.4 Any requirements for prior approval of medical care including elective procedures, surgeries, and/or hospitalizations;						
1.5 Procedures for and restrictions on obtaining out-of-network medical care;						The *Member Handbook* and *Policy SC.UM.42, Out of Network and Referral Services,* define these procedures.
1.6 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services;						
1.7 Procedures for post-stabilization care services;						
1.8 Policies and procedures for accessing specialty/referral care;						
1.9 Policies and procedures for obtaining prescription medications and medical equipment, including applicable copayments and formulary restrictions;						*The Member Handbook* and *Policies CC.PHAR.08, 09 and 10,* address member access to prescription drugs, over-the-counter medication and emergency supplies.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.10 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network, and providing assistance in obtaining alternate providers;						
1.11 Procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						
1.12 Procedures for disenrolling from the MCO;						
1.13 Procedures for filing grievances and appeals, including the right to request a Fair Hearing through SCDHHS;						The *Member Handbook*, *Policy SC.UM.11, Member Grievances*, and *Policy SC.UM.13, Member Appeals*, include information on grievances, appeals, and State Fair Hearings.
1.14 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for their care and of alternate languages spoken by the provider's office;						
1.15 Instructions on how to request interpretation and translation services when needed at no cost to the member;						
1.16 Member's rights and protections, as specified in 42 CFR §438.100;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.17 Description of the purpose of the Medicaid card and the MCO's Medicaid Managed Care Member ID card and why both are necessary and how to use them;						The member ID card submitted with requested materials does not include the PCP practice name. Onsite discussion revealed that *SCDHHS* instructed ATC that as long as the PCP name or the PCP practice name is present, the member ID card is acceptable.
1.18 A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;						
1.19 How to make, change and cancel medical appointments and the importance of canceling and/or rescheduling rather than being a "no show";						
1.20 Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services						Complete information is found in the *Member Handbook*.
1.21 A description of Advance Directives, how to formulate an advance directive and where a member can received assistance with executing an advance directive;						Minimum information on Advance Directives is found in the *Member Handbook*; however, additional information is found on the ATC website. *SCDHHS Contract, Section 3.14.1.7.3*, directs that members are to be educated on where they can seek assistance in executing an Advance Directive and to whom copies should be given. *The Member Handbook* does include who should receive a copy of the member's Advance Directives; however, no information is included about where a member might obtain assistance to execute an Advance

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Directive. *Recommendation: Include in the Member Handbook where members can seek assistance to formulate and execute an Advance Directive. Consider developing a brochure that could be sent to members requesting additional information.*
1.22 The SCDHHS fraud hotline and fraud email address and toll-free line;						ATC's fraud hotline is anonymous and the number is available in the *Member Handbook, the Provider Manual,* and on the website.
1.23 Additional information as required by the contract and by federal regulation.						*The Member Handbook* change control log is found on the ATC website.
2. Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network.	X					*The Member Handbook and Policy SC.MBRS.12, Enrollee Notification*, states members are notified of new benefits or benefit changes via the member newsletter, addendums to the *Member Handbook*, new member orientation, and/or letters. This is accomplished at least 30 days before the changes are effective. *Policy SC.ELIG.14, Member Notification of Provider Termination,* states "the contractor must make a good faith effort to give written notice of termination of a contracted provider, within fifteen (15) days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. Member program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation for prevalent non-English languages as required by the contract.	X					*Policy SC.COMM.19, Member Materials Readability,* states ATC adheres to the following: •6.9 reading level per Flesch-Kincaid reading scale in Word •Clear and understandable •Non-English prevalent equals 5% or greater for non-English language translation •Documentation is submitted to SCDHHS for approval, and •ATC has bilingual Member Services staff. ATC provides free aids and services to people with disabilities, such as qualified sign language interpreters and written information in other formats (large print, braille, audio, accessible electronic formats, other formats). Free language services are available to people whose primary language is not English, such as qualified interpreters and information written in other languages. The *Member Handbook* and other documents and brochures are available in Spanish.
4. The MCO maintains and informs members of how to access a toll-free vehicle for 24-hour member access to coverage information from the MCO, including the availability of free oral translation services for all languages.	X					ATC's toll-free member hotline is staffed with member services representatives (MSRs) during normal business hours (8:00 am to 6:00 pm EST Monday through Friday) and by NurseWise, ATC's 24-hour nurse information and triage line (after hours and on weekends and holidays). The ATC call center responsiveness data consistently meets and surpasses goals for speed to answer and abandonment rates. Second quarter 2016 rates were: 1.94% abandonment rate, speed to answer less than 00:16 seconds, and service levels

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						approximately 90%. The *Member Handbook* informs members how to obtain free oral translation services available on any call to ATC. It contains a multi-lingual listing of contact information on translation services.
5. Member grievances, denials, and appeals are reviewed to identify potential member misunderstanding of the MCO program, with reeducation occurring as needed.	X					Onsite discussion confirmed ATC uses member connectors to conduct face-to-face education to members about benefits and services. Member assistance is available for filing appeals and grievances. Telephone outreach calls are made to re-educate members on appropriate use of benefits, including emergency room use.
6. Materials used in marketing to potential members are consistent with the state and federal requirements applicable to enrollees and members.	X					
III C. Member Disenrollment						
1. Member disenrollment is conducted in a manner consistent with contract requirements.	X					*Policy SC.MBRS.01, Disenrollment for Cause,* defines ATC's process for member initiated disenrollment for cause. A review of several files demonstrates that ATC is following their process which meets contract requirements. Onsite discussions confirmed that ATC attempts to contact each member 3 times about the request to leave the MCO. Calls may result in meeting the unmet need and the member remaining with ATC.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III D. Preventive Health and Chronic Disease Management Education						
1. The MCO enables each member to choose a PCP upon enrollment and provides assistance as needed.	X					It is the policy of ATC to auto-assign a new PCP to members who have failed to choose an in-network PCP or those who are auto-enrolled with ATC without a PCP. If the member makes contact through the call center and selects a new PCP, the MSRs will notate and complete the PCP change in customer data system. The change is reflected immediately and a new member ID card is generated and sent to the member. Members can request a change in their PCP by using a form provided on the ATC website, calling Member Services, or submitting a PCP change form in writing. *The Member Handbook* states ATC will assist members choosing a new PCP.
2. The MCO informs members about the preventive health and chronic disease management services that are available to them and encourages members to utilize these benefits.	X					ATC adopts Clinical and Preventive Practice Guidelines for the provision of acute, chronic and behavioral health services relevant to the populations served. Preventive practice guidelines are developed for pediatric, adolescent, and adult populations. The guidelines are derived from recognized sources and are presented to the QI Committee for appropriate physician review and adoption. The *Member Handbook* lists preventive guidelines and directs members to the ATC website or Member Services call center for more information. Well-

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						child visits are detailed in the *Member Handbook* along with a schedule for the visits. ATC encourages preventive health for children and adults by sending written reminders and conducting direct outreach in person or on the phone. ATC provides member incentives for completing these activities. Providers are informed about these guidelines in the *Provider Manual* and ATC website.
3. The MCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in their recommended care, including participation in the WIC program.	X					ATC identifies pregnant members from multiple sources: •Notice of Pregnancy (NOP) form •Eligibility lists •Claims and reports •Providers •Health Risk Assessments •Prior authorization and concurrent review processes and, •CM and hospital case managers. Telephone NOP assessments are conducted and members are stratified according to CM needs. Members receive information about Start Smart for your Baby and contact with high-risk OB case managers as applicable. ATC attempts to eliminate barriers to care for members by arranging transportation or addressing other needs that impact the ability to follow recommended pre and post-natal care. Incentives are offered for completing this care. ATC has identified serious barriers to care include substance

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						abuse by the mother and a change in criteria for Makena use. In response, ATC will continue to pay for Makena to be administered in the home. ATC is also developing a program to address substance abuse in pregnant women.
4. The MCO tracks children eligible for recommended EPSDTs and immunizations and encourages members to utilize these benefits.	X					*Policy SC.QI.25, EPSDT Program Description,* explains how ATC identifies and tracks participation in the Well-Child/EPSDT program. The ATC EPSDT program supports its providers to also encourage member participation. Reminders are sent to parents when well-child examinations and immunizations are due. Reminders can be via member newsletters, reminder mailings, and/or telephonic outreach. ATC may use claims or encounter data and pharmacy data, where applicable, to identify members eligible for wellness activities: ATC's informing and outreach efforts include: •The *Member Handbook* •Educational mailings •Live and auto-dialer calls •Care gaps alerts are posted to the member secure portal and, •Member education/information through Start Smart for Your Baby Program in which new moms enrolled in the program qualify for an incentive if their newborn completes the first three EPSDT outpatient screenings by the third month of life.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						ATC educates providers on EPSDT requirements and billing procedures. ATC provides a member non-compliant list to providers along with additional training and resources available to providers. Providers may receive performance-based incentives for improving EPSDT performance measure outcomes and the quality of care and services.
5. The MCO provides educational opportunities to members regarding health risk factors and wellness promotion.	X					
III E. Member Satisfaction Survey						
1. The MCO conducts a formal annual assessment of member satisfaction with MCO benefits and services. Such assessment includes, but is not limited to:	X					The child and adult CAHPS survey was performed by SPH Analytics, a NCQA certified vendor. The overall response rate was 27.7% for the CAHPS Adult survey and 24.5% for the CAHPS child survey. The target response rate according to NCQA is 40.0%. The response rate was below the NCQA target rate. *Recommendation: Implement strategies to increase response rates for both adult and child CAHPs surveys. Work with your vendor to find ways to reach more respondents.*
1.1 Statistically sound methodology, including probability sampling to ensure that it is representative of the total membership;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.2 The availability and accessibility of health care practitioners and services;	X					
1.3 The quality of health care received from MCO providers;	X					
1.4 The scope of benefits and services;	X					
1.5 Claim processing procedures;	X					
1.6 Adverse decisions regarding MCO claim decisions.	X					
2. The MCO analyzes data obtained from the member satisfaction survey to identify quality problems.	X					Results were analyzed by the vendor and summarized by ATC.
3. The MCO implements significant measures to address quality problems identified through the member satisfaction survey.	X					ATC has a policy and procedure in place to look through the results of the survey, identify and prioritize the issues, and respond to the issues to improve member satisfaction. The results were also discussed during QIC committee meetings.
4. The MCO reports the results of the member satisfaction survey to providers.	X					The ATC provider Winter/Spring 2016 Newsletter presented results for 2015 child CAHPS survey; this newsletter refers the reader to the 2015 provider newsletter for the adult results. The results are also posted on the ATC provider website.
5. The MCO reports to the Quality Improvement Committee on the results of the member satisfaction survey and the impact of measures taken to address those quality problems that were identified.	X					Results were shared with the QIC and found in the meeting minutes dated 4/26/16.
III F. Grievances						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to:	X					*Policy SC.UM.11, Member Grievances*, defines ATC's process for receiving, acknowledging, investigating, resolving grievances and providing notice to members and/or providers regarding the outcome of the investigation.
1.1 Definition of a grievance and who may file a grievance;	X					
1.2 The procedure for filing and handling a grievance;	X					The *Member Handbook*, page 40, instructs members on who file a grievance, how to file and that ATC can provide assistance to file a grievance. Grievance forms are found on the ATC website as required by the *SCDHHS Contract*. All of the following documents include 1) filing within 30 days of the occurrence, 2) providing assistance to file, 3) acknowledging within 5 calendar days, and 4) grievances can be filed orally or in writing. •*The Member Grievance Policy SC.UM.11* •*The Provider Manual* •*The Member Handbook* ATC has a second level grievance process if the member is not satisfied with the original grievance resolution. It follows the same procedure as the first and must be filed within 30 days of receipt of the first resolution.
1.3 Timeliness guidelines for resolution of the grievance as specified in the contract;	X					Consistently documented in accordance with contract requirements.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;		X				*Policy SC.UM.11, Member Grievances*, states, "grievances that involve clinical issues will be reviewed by a health care professional who has the appropriate expertise, as determined by the State, in treating the members' condition or disease." The policy does not indicate that the same reviewer expertise also applies to those who make decisions on grievances related to the denial of a request for an expedited appeal. See item 2 in the *SCDHHS Contract, Section 9.1.4.3.2.* which states "Who, if deciding: (1) an Appeal of a denial based on lack of Medical Necessity; (2) a Grievance regarding denial of expedited resolution of an Appeal; or (3) a Grievance or Appeal that involves clinical issues, are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the Medicaid Managed Care Member's condition or disease." *Quality Improvement: Include in policy SC.UM.11 that a grievance regarding the denial of expedited resolution of an appeal, will be decided by health care professional appropriate clinical expertise, as determined by the State, in treating the Medicaid Managed Care Member's condition or disease.*
1.5 Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract.	X					ATC retains records according to *Policy CC.LEGL.01 Records Management, Attachment A*, indicates this period is 10 years.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The MCO applies the grievance policy and procedure as formulated.		X				A review of a random selection of 20 grievance files was conducted as part of the desk review and findings were discussed with ATC during the onsite visit. The files reviewed were resolved within the 90-day timeframe in all but one case. All files contained timely written acknowledgement of receipt by ATC. It appears that ATC makes appropriate referrals for quality of care issues, grievances about providers, and conditions of provider offices or facilities. Onsite discussion revealed that even though some steps necessary to resolve the grievance were not documented, the appropriate action was taken by the health plan. The other weak point in the process appears to be when grievances are referred to other departments for action. Several attempts were required by grievance and appeal coordinator to obtain the resolution. The department resolving the grievance did not document phone calls or contacts made to obtain resolution. The information was not documented in the file; however, it was included in the grievance resolution letter. *Policy SC.UM.11, Member Grievances* states "a standardized note template documenting the details, verbal and written responses, resolution, as well as member notifications will be followed to ensure consistent documentation in the electronic system." *Quality Improvement: Ensure the template used to document grievance resolution includes a place for*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						each employee or department to document actions taken and contacts made in the process of resolving the grievance.
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					*Policy SC.UM.11, Member Grievances*, indicates the records of all grievances are maintained by ATC and reviewed by the QI department to identify trends and opportunities to improve the quality of care and service. Grievances related to possible quality of care are forwarded to the QI department for investigation and resolution, including involving the medical director in the process. *Policy SC.QI.17, Monitoring Clinical Quality of Care* and its attachments detail the processes used in handling quality of care grievances. Evidence of grievance trending was evident in the QIC minutes. The majority of the grievances received by ATC were related to balance billing.
4. Grievances are managed in accordance with the MCO confidentiality policies and procedures.	X					
III G. Practitioner Changes						
1. The MCO investigates all member requests for PCP change in order to determine if such change is due to dissatisfaction.	X					Onsite discussion confirmed that ATC investigates all member requests to change their PCP.
2. Practitioner changes due to dissatisfaction are recorded as grievances and included in grievance tallies, categorization, analysis, and reporting to the Quality Improvement Committee.	X					Onsite discussion confirmed ATC does create a grievance when a member requests to change their PCP due to dissatisfaction. The process of recording any request for PCP change due to dissatisfaction, as a grievance was not located in policy *SC.MBRS.02, PCP Change/Selection, Policy*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						SC.UM.11, Member Grievances, or any other document. *Recommendation: Develop a new policy or include in an active policy ATC's process to create a grievance when a member requests to change their PCP due to dissatisfaction. Define how this information is used to identify opportunities for improvement.*
3. The timeliness guideline for completing a member's request to change their PCP is consistent with contract requirements.	X					

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV. QUALITY IMPROVEMENT						
IV A. The Quality Improvement (QI) Program						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to members.	X					ATC provided the 2016 *Quality Assessment and Performance Improvement Program Description* for review. This program description described the program the health plan has in place to monitor, analyze, evaluate, and improve the health care provided to all members. Page 17 of the program description discusses continuity of care and mentions the process followed when a member is affected by the termination of a provider. The timeframe for notifying a member of this termination is incorrect. According to *Policy SC.ELIG.14, Member Notification of Provider Termination,* and *42 CFR § 438.10 (f),* the health plan must make a good faith effort to give written notice of termination of a contracted provider within 15 days after receipt of the termination notice. *Recommendation: Correct the timeframe for notifying affected members of a terminated provider in the Quality Improvement Program Description.*
2. The scope of the QI program includes monitoring of provider compliance with MCO wellness care and disease management guidelines.	X					Annually, ATC measures practitioner compliance with at least two aspects of the adopted clinical practice guidelines. The results of this analysis was presented in the 2015 program evaluation and demonstrated all practitioners measured received a passing score.
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					This requirement is addressed on page 18 of the program description. Results of the monitoring of utilization patterns are reported to the Quality Improvement Committee.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s).	X					
IV B. Quality Improvement Committee						
1. The MCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					ATC has established a committee structure with various subcommittees and ad-hoc committees responsible for monitoring and supporting the quality improvement activities and programs. The QIC has been established to provider oversight and directions in assessing the appropriateness of care and service delivery provided to members.
2. The composition of the QI Committee reflects the membership required by the contract.	X					
3. The QI Committee meets at regular quarterly intervals.	X					The QIC meets at least quarterly.
4. Minutes are maintained that document proceedings of the QI Committee.	X					All committee activities are documented in meeting minutes. The QIC minutes submitted with the desk materials were well documented, included the committee's discussion, decisions, and any follow-up needed.
IV C. Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					All performance measures were fully compliant, and the full report was offered showing validation using Inovalon software. HEDIS rates show a decline in childhood immunization for most of the measures,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						with two of the measures decreasing more than 10% from the previous year. Further evaluation of the reasons for these decreases is warranted. The complete validation results are found in *Attachment 3, EQR Validation Worksheet*. *Recommendation: Further evaluation to determine the reason for the decline in the childhood* immunization rates is warranted.
IV D. Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population.	X					There were two performance improvement projects submitted for this year's desk review. Both projects had a justified rationale using analysis of data, and the research questions were stated clearly. Furthermore, documentation was well-organized and results were presented clearly and accurately. Interventions are applicable to the project goals. So, the QIPs were fine.
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".	X					Documentation was well-organized and results were presented clearly and accurately. Both projects scored within the *High Confidence Range* and met the validation protocol. The complete validation results are found in *Attachment 3, EQR Validation Worksheet*.
IV E. Provider Participation in Quality Improvement Activities						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO requires its providers to actively participate in QI activities.	X					
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					Annually physicians receive their results of specific HEDIS measures that are applicable to the provider's patient population. Interventions may be implemented to address any performance not meeting established goals.
IV F. Annual Evaluation of the Quality Improvement Program						
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	X					The *Quality Assessment and Performance Improvement Program Evaluation* for 2015 and the Cenpatico 2015 *Quality Improvement Program Evaluation* were provided in the desk materials. Both program evaluations provided an assessment of the accomplishments for 2015.
2. The annual report of the QI program is submitted to the QI Committee and to the MCO Board of Directors.	X					

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V. Utilization Management						
V A. The Utilization Management (UM) Program						
1. The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					The *Utilization Management (UM) Program Description* defines the purpose, scope, goals, and oversight of the UM Program. Processes for performance of UM functions are detailed in departmental policies.
1.1 structure of the program and methodology used to evaluate the medical necessity;	X					
1.2 lines of responsibility and accountability;	X					The *UM Program Description* defines lines of responsibility and accountability for the UM Program. ATC's QIC has oversight and operating authority for UM activities. The medical director has operational responsibility for and provides support to the UM Program. The medical director, vice president of medical management (VPMM), and director of utilization management are responsible for implementing the UM Program. A registered pharmacist oversees the implementation, monitoring, and directing of pharmacy services; and a medical director with a specialty in psychiatry oversees behavioral health activities. Daily oversight and operating authority of UM activities is delegated to the VPMM and director of utilization management.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 guidelines / standards to be used in making utilization management decisions;	X					Guidelines used in medical necessity determinations are documented in the *UM Program Description* and *Policy SC.UM.02, Clinical Decision Criteria and Application*. The Cenpatico *UM Program Description* (CCL.001) and *Policy CCL.129, Clinical Practice Guidelines*, define criteria used for behavioral health and substance abuse services.
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					Timeliness requirements for authorization determinations are appropriately documented in the *UM Program Description*, *Policy SC.UM.05, Timeliness of UM Decisions and Notifications*, the *Member Handbook*, and the *Provider Manual*. A discrepancy in the timeframe for requesting authorizations was noted: •ATC's website states prior authorization requests should be submitted at least 5 business days before the scheduled service delivery date. •*Policy SC.UM.05, Timeliness of UM Decisions and Notifications*, page 1, states prior authorization must be requested within 10 days prior to the requested service date. During onsite discussion of this issue, ATC staff confirmed the policy should be updated to reflect the timeframe listed on the ATC website. Refer to: https://www.absolutetotalcare.com/providers/resources/prior-authorization.html *Recommendation: As discussed during the onsite visit, revise Policy SC.UM.05 to state prior authorization must be requested at least 5 business*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						days before the scheduled service delivery date.
1.5 consideration of new technology;	X					*Policy SC.UM.02, Clinical Decision Criteria and Application,* confirms Centene's Clinical Policy Committee determines medical policy related to new and emerging technologies and new uses for existing technologies. These medical policies are made available to medical directors and Level I reviewers. *Work Process SC.UM.02.01, Medical Necessity Review*, confirms the following are referred for Level II (medical director) review: •requests which require benefit interpretation •requests which are not addressed in InterQual criteria and no local criteria or policy exists •requests for services or procedures which are new or potentially experimental
1.6 the absence of direct financial incentives or established quotas to provider or UM staff for denials of coverage or services;	X					ATC and its delegated entities do not permit or provide compensation or anything of value to employees, agents, or contractors based on the percentage of the amount by which a claim is reduced for payment, or the number of claims or the cost of services for which the person has denied authorization or payment; or any other method that encourages the rendering of an adverse determination.
1.7 the mechanism to provide for a preferred provider program.	X					*Policy SC.UM.54, Preferred Provider Designation*, outlines the requirements to achieve Preferred

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Provider Designation (Preferred Status) for providers or institutions recognized for consistent management of care based on quality and practice guidelines. Preferred Status exempts providers from prior authorization requirements, allows for expedited prior authorization processing, and/ or simplifies documentation requirements for prior authorization requests. The policy defines eligibility criteria for Preferred Status consideration as well as limitations to the designation. Onsite discussion confirmed one provider has achieved Preferred Status since implementation of the program and additional providers are being evaluated for inclusion into the program.
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					Dr. Robert Thompson, ATC's medical director, has operational responsibility for and provides support to the UM Program. Along with the VPMM, director of UM, and designees assigned by CEO, Dr. Thompson is responsible for implementing the UM Program including cost containment, medical quality improvement, medical review activities, and quality improvement. A registered pharmacist oversees the implementation, monitoring and directing of pharmacy services. A medical director with a specialty in psychiatry oversees activities related to behavioral health. Medical director consultants include Dr. Cantey, Dr. Mittal, and Dr. Walker-McGill.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.	X					ATC conducts annual UM Program evaluations at least annually and makes modifications as needed. The evaluation covers all aspects of the UM Program, including member complaint, grievance, and appeal data; member satisfaction survey results; practitioner complaints; practitioner satisfaction surveys; UM data; practitioner profiles; and drug utilization review profiles (where applicable). The evaluation identifies problems and/or concerns and includes recommendations for removing barriers to improvement. The evaluation and recommendations are submitted to the QIC for review and approval. UM criteria are nationally recognized, evidence-based standards of care and include input from recognized medical experts. UM criteria and the policies for application are reviewed at least annually and updated as appropriate with involvement from physician members of the QIC and in conjunction with Centene Corporate Medical Management leadership.
V B. Medical Necessity Determinations						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					InterQual guidelines and established corporate medical policies are used to determine medical necessity and appropriateness of physical health care. Cenpatico uses InterQual criteria for mental and behavioral health determinations, and American Society of Addiction Medicine criteria for substance abuse reviews.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					UM files reflected use of appropriate criteria and appropriate attempts to obtain additional clinical information when needed to render a determination.
3. Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations.	X					
4. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					*Policy SC.UM.02, Clinical Decision Criteria and Application*, confirms Level I and Level II reviews are conducted using approved medical necessity criteria along with consideration of the individual member needs and local delivery system available for care.
5. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					Inter-rater reliability (IRR) testing is performed on all staff involved in decision making to ensure consistency in documentation and determinations. The threshold for passing scores is 90%. New employees and temporary staff are tested before working in the live authorization system and all InterQual users are tested at least yearly. IRR results are reported to all leadership and to the QIC. *Work Process CC.UM.02.05, Interrater Reliability*, defines processes for IRR scores of less than 90%, including retraining and retesting. Inability to pass retesting may warrant further action, up to and including termination of employment. Onsite discussion revealed that of more than 45 staff members tested, only 4 required retesting and all successfully passed.
6. Pharmacy Requirements						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	X					
6.2 If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity.	X					*Policy SC.PHAR.01, Five (5) Day Emergency Supply Of Medication*, confirms ATC authorizes a 5-day supply of medication pending prior authorization. The policy defines drugs excluded from the 5-day emergency supply of medication. *Policy SC.PHAR.06, Pharmacy Lock-In Program*, addresses provisions to allow members to obtain a 5-day emergency supply of medication at pharmacies other than the designated lock-in pharmacy to ensure the provision of necessary medication required in an emergency.
7. Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations.	X					*Policy SC.UM.12, Emergency Services*, uses the prudent layperson definition of an emergent situation and defines requirements for coverage of emergency and post-stabilization services in compliance with *Federal Regulation §438.114* and the *SCDHHS Contract, Section 4.6.12*.
8. Utilization management standards/criteria are available to providers.	X					
9. Utilization management decisions are made by appropriately trained reviewers.	X					
10. Initial utilization decisions are made promptly after all necessary information is received.	X					UM files reflected timely authorization determinations and notification of the decision to members and providers.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
11. Denials						
11.1 A reasonable effort that is not burdensome on the member or the provider is made to obtain all pertinent information prior to making the decision to deny services.	X					UM denial files confirmed attempts are made to obtain additional information when necessary to render a medical necessity determination.
11.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					UM denial files confirmed physicians with appropriate specialties rendered all denial determinations.
11.3 Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal.	X					UM denial files reflected timely decisions and notifications. Notice of action letters were written in appropriate language for ease of member understanding, contained the rationale for the denial along with references to the criteria used, and supplied information on how to request an appeal.
V C. Appeals						
1. The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an action by the MCO in a manner consistent with contract requirements, including:	X					*Policy SC.UM.13, Member Appeals*, describes ATC's process for resolving member disputes and responding to member appeal requests. Information on appeals processes is also found in the *Member Handbook* and *Provider Manual*.
1.1 The definitions of an action and an appeal and who may file an appeal;	X					
1.2 The procedure for filing an appeal;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;		X				*Policy SC.UM.13, Member Appeals*, describes requirements and processes for expedited appeals, and states ATC will review a request for an expedited appeal to determine if the request involves an imminent and/or serious threat to the health of the member. The policy does not define which staff members are allowed to make this determination. Onsite discussion confirmed that only medical directors issue a determination to deny an expedited appeal timeframe. *Quality Improvement Plan: Revise Policy SC.UM.13, Member Appeals, to define which staff members are allowed to make the determination to deny an expedited appeal timeframe.*
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					Timeliness requirements for standard and expedited appeal resolution and notification, as well as extensions of the timeframes, are correctly documented in *Policy SC.UM.13, Member Appeals*, the *Member Handbook*, the *Provider Manual*, and in the PA Denial Letter template. *Policy SC.UM.13, Member Appeals*, page 4, states the timeframe for resolution of an appeal filed by a provider on behalf of a member begins when the signed member's

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						consent is received.
1.6 Written notice of the appeal resolution as required by the contract;	X					*Policy SC.UM.13, Member Appeals*, details required components of the written appeal resolution notice.
1.7 Other requirements as specified in the contract.	X					*Policy SC.UM.13, Member Appeals*, specifies conditions under which continuation of benefits pending an appeal outcome may be approved. Appropriate information regarding continuation of benefits is found in the *Member Handbook* and *Provider Manual*.
2. The MCO applies the appeal policies and procedures as formulated.	X					CCME's review revealed that appeal files were thoroughly documented, reflected determinations were made by appropriate reviewers, and determinations and notifications were timely. Appeal resolution letters contained all required elements and were written in appropriate language for ease of member understanding.
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					ATC maintains records of all appeals. Appeals data is reviewed by the Quality Improvement department to identify trends and opportunities to improve quality of care and service. QIC minutes reflect the committee's review and discussion of appeals data.
4. Appeals are managed in accordance with the MCO confidentiality policies and procedures.	X					Processes to ensure confidentiality of PHI include: •Staff, consultants, and ATC committee members are required to sign confidentiality statements •Medical information sent by mail or fax is clearly marked "personal and confidential" •Printed medical information is secured under lock and key with access only by essential personnel

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•Medical information stored in the software system is protected under multiple levels of security by system configuration including user access passwords.
V. D Case Management						
1. The MCO utilizes case management techniques to ensure comprehensive, coordinated care for members with complex health needs or high-risk health conditions, including populations specified in the contract.	X					The scope, goals, objectives, and functions of ATC's CM program are documented in the *Care Management Program Description*. CM policies provide further detail and guidance on CM functions and processes. ATC uses an integrated care team staffing model for CM, allowing licensed staff to focus on complex and clinically-based service coordination needs while unlicensed staff perform non-clinical service coordination and administrative functions. CM files reflected established processes are followed in assessment, care plan development, and member follow-up.
V E. Evaluation of Over/ Underutilization						
1. The MCO has mechanisms to detect and document under and over utilization of medical services as required by the contract.	X					*Policy SC.UM.01.03, Monitoring Utilization*, defines ATC's processes for monitoring and analyzing relevant data to detect and correct patterns of potential or actual over or underutilization of services and resources.
2. The MCO monitors and analyzes utilization data for under and over utilization.	X					ATC analyzes utilization data on the following topics: •Inpatient admissions •Inpatient days per 1000 members •Inpatient LOS

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•BH Inpatient admissions, days, and LOS •ED visits •Readmission rates •Neonate Rate

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I. DELEGATION						
1. The MCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					ATC's delegation process includes obtaining written delegation agreements for all delegated entities. The delegation agreements specify the functions delegated and include information on oversight, monitoring, and corrective action for substandard performance of delegated functions.
2. The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions.	X					Several policies address delegation such *as Policy SC.COMP.14, Oversight of Delegated Vendors*, and *Policy CC.CRED.12, Oversight of Delegated Credentialing*. ATC's oversight process includes annual audits, quarterly oversight by committees, monthly and quarterly review of delegated vendor reports, and initiation of corrective action plans when necessary.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Evidence of oversight was received for all delegated entities. Annual audits were conducted and corrective action plans were implemented if audit results indicated a need.

VII. STATE-MANDATED SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I I. STATE-MANDATED SERVICES						
1. The MCO tracks provider compliance with:						
1.1 administering required immunizations;	X					ATC's *EPSDT Program Description* is evaluated through the annual evaluation of the Quality Improvement Program. The program requires providers to perform EPSDT medical check-ups in their entirety and at intervals required by the AAP Recommendations for Preventive Pediatric Health Care. All examination components, including immunizations, must be documented and included in the medical record of each EPSDT eligible member. Provider compliance with provision of required immunizations is monitored via medical record compliance audits.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.2 performing EPSDTs/Well Care.	X					ATC's EPSDT Program includes all components specified in the *SCDHHS Policy & Procedure Guide, Section 4.1.* Members are informed of available EPSDT services via the *Member Handbook*, educational mailings, live and auto-dialer calls, care gaps posted to the secure member portal, and in information included in the Start Smart for Your Baby Program. ATC uses the claims/encounter and pharmacy data to identify members eligible for wellness activities. The data is used to identify members who may benefit from outreach to engage in wellness activities. Provider compliance with provision of EPSDT services is monitored via medical record compliance audits.
2. Core benefits provided by the MCO include all those specified by the contract.	X					
3. The MCO addresses deficiencies identified in previous independent external quality reviews.	X					